



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 30, 2025

Licensee

Mn Best Homecare LLC

9737 3rd Street Northeast

Minneapolis, MN 55434

RE: Project Number(s) SL36617016

Dear Licensee:

On May 8, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 5, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 5, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 5, 2025, found not corrected at the time of the May 8, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1290 - Background Studies Required - 144g.60 Subdivision 1

The details of the violations noted at the time of this follow-up survey completed on May 8, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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>

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

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36617	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/08/2025
NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9737 3RD STREET NE MINNEAPOLIS, MN 55434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#36617016-1 On May 5, 2025, through May 8, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 3, 2025. At the time of the survey, there were four residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{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.		
{0 330} SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	{0 330}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 330}	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by:	{0 330}	Not reviewed during survey		
{0 420} SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by:	{0 420}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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	{0 480}			

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{0 480}	Continued From page 2 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 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	{0 480}			

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{0 480}	Continued From page 3 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:	{0 480}			
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Not reviewed during survey	{0 485}			
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	{0 550}	Not reviewed during survey		

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{0 550}	Continued From page 4 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by:	{0 550}	Not reviewed during survey		
{0 660} SS=D	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.	{0 660}			

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{0 660}	Continued From page 5 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during survey		
{0 730} SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	{0 730}			

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{0 730}	Continued From page 6 resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}	Not reviewed during survey		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	{0 780}			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**9737 3RD STREET NE
MINNEAPOLIS, MN 55434**

Minnesota Department of Health
STATE FORM

Minnesota Department of Health

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{0 810}	Continued From page 8 (2) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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:	{0 810}			
{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	{01290}			

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{01290}	Continued From page 9 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 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 interview and record review, the licensee failed to ensure a background study was affiliated with the licensee's health facility identification number (HFID) for one of eight unlicensed personnel ((ULP)-D). 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: ULP-D was hired on March 28, 2023. According to Minnesota Department of Health Netstudy2 website accessed on May 6, 2025, at 8:39 a.m., ULP-D was not affiliated to the licensee's HFID 36617.	{01290}			

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{01290}	Continued From page 10 ULP-D's Background Study Clearance dated May 6, 2025, indicated ULP-D was associated to the licensee's HFID after the initiation of follow up survey on May 5, 2025. On May 6, 2025, at 9:38 a.m., licensed assisted living director (LALD)-C stated ULP-D was currently affiliated to another facility owned by the same owner only. LALD-C stated they had talked about this at the last survey but did not realize they were supposed to affiliate ULP-D to this facility as well. LALD-C confirmed ULP-D currently worked for both locations owned by the licensee's owner. The licensee's Personnel Records policy dated August 1, 2021, indicated licensee would maintain current results of background studies in each employees' personnel record. This citation had an immediate correction date on February 3, 2025. No further information provided.	{01290}			
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal	{01370}			

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{01370}	Continued From page 11 hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during survey		
{01470} SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision	{01470}			

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{01470}	Continued From page 12 of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication;	{01470}			

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STATE FORM 6899 8GOS12 If continuation sheet 14 of 18

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{01500}	Continued From page 14 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 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:	{01500}	Not reviewed during survey		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36617	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/08/2025
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{01500}	Continued From page 15	{01500}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be 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:	{01620}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide	{01790}	Not reviewed during survey		

Minnesota Department of Health

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{01790}	Continued From page 16 medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident,	{01790}			

**9737 3RD STREET NE
MINNEAPOLIS, MN 55434**

Not reviewed during survey



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 2, 2025

Licensee

MN Best Homecare, LLC
9737 3rd Street Northeast
Minneapolis, MN 55434

RE: Project Number(s) SL36617016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 5, 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.

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.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

MN Best Homecare, LLC

April 2, 2025

Page 3

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,

A handwritten signature in black ink, appearing to read 'Jess', with a horizontal line extending to the right.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36617	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2025
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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: SL36617016-0 On February 3, 2025, through February 5, 2025 the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents receiving services under the Assisted Living Facility license. On February 3, 2025, an immediate correction order was issued for tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. On February 4, 2025, an immediate correction order was issued for tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and 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 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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 4, 2025, at 9:22 a.m., the surveyor provided licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C a Request for Copies survey form for R2's documents being requested that included a signed service plan for R2. On February 4, 2025, at 10:21 a.m., the surveyor	0 330			

Minnesota Department of Health

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0 330	Continued From page 2 received a folder with R2's records with no explanation regarding R2 records. R2's records received did not include a signed service plan. On February 5, 2025, at 9:22 a.m., the surveyor requested R3's signed service plan and notified licensee the surveyor still needed R2's signed service plan. On February 5, 2025, at 10:15 a.m. the surveyor received R2 and R3's service plans with no explanation regarding R2 and R3's service plans. R2 R2 was admitted on June 28, 2023, with a diagnosis of spinal card injury ((cervical) C5-C7). On February 4, 2025, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. R2's Service Plan with an effective date of February 5, 2025, indicated R2's services included assistance with bathing, catheter care, dressing, drinking, exercise/passive range of motion, grooming, G-tube care, housekeeping, irrigation/flush, laundry, linen change, meal assistance, meal reminder, meal tray, medication assist, medication administration, medication setup, and transfer assist. R2's Service Plan was signed by the resident and licensee with a date of July 6, 2023, which was one year, six months, four weeks, and two days prior to the effective date of the service plan. R3 R3 was admitted on May 2, 2023, with diagnoses of diabetes and autism-Aspergers syndrome (neurodevelopmental disorder that affects emotion, communication and behavioral skills).	0 330			

Minnesota Department of Health

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0 330	Continued From page 3 On February 4, 2025, at 9:06 a.m., the surveyor observed ULP-A assist R3 with medication administration. R3's Service Plan with an effective date of February 5, 2025, indicated R3's services included assistance with activities, bathing, colostomy changes, dressing, grooming, housekeeping, laundry, meal assistance, meal prep, medication administration, medication set up, skin care, TED stockings and vital sign monitoring. R3's Service Plan was signed by the resident and licensee with a date of May 20, 2023, which was one year, eight months, two weeks, and two days prior to the effective date of the service plan. On February 5, 2025, at 11:55 a.m., the surveyor asked the licensee if they had any previous signed service plans that were effective prior to February 5, 2025. LALD/CNS-C stated they did not have any signed service plans prior to today so licensed practical nurse (LPN)-E had the residents sign them today. On February 5, 2025, at 12:21 p.m., the surveyor asked the licensee to explain why the service plans indicated an effective date of February 5, 2025, but were signed with a date prior to the effective date of the service plan. LALD/CNS-C stated R2 and R3's service plans were back dated today, for some reason the licensee could not find the signed service plans for these two residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			

Minnesota Department of Health

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0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective August 1, 2021. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that,	0 420			

Minnesota Department of Health

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0 420	Continued From page 5 as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner on September 10, 2024. As a result of this survey, the following orders were issued under 0330, 0420, 0480, 0485, 0550, 0660, 0730, 0775, 0780, 0800, 0810, 1290, 1370, 1470, 1500, 1620, 1790, 1880, 3090, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			

Minnesota Department of Health

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0 480	Continued From page 6	0 480			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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;	0 480			

Minnesota Department of Health

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0 480	Continued From page 7 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are 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 February 3, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 8	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have menus prepared at least one week in advance and made available to all residents. This had the potential to affect all three residents who received services. 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	0 485			

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0 485	Continued From page 9 residents). The findings include: On February 3, 2025, at 10:29 a.m., the surveyor observed the licensee's menu posted in the common dining room area. The Menu was inside a plastic sleeve and showed the menu plan for January 4, 2025, through January 10, 2025. The surveyor observed three other sheets inside the plastic sleeve behind the first page that included other weeks menu plans. The last date of menu plans included inside of the plastic sleeve was noted to be January 31, 2025. On February 3, 2025, at 1:34 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated it was an oversight not to have the menu posted at least seven days in advance as they normally post the menus every month. LALD/CNS-C stated the last day posted was just three days ago. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	0 550			

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0 550	Continued From page 10 for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the grievance procedure along with the required contact information. This had the potential to affect all the licensee's 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). The findings include: On February 3, 2025, at 11:26 a.m., during a facility tour, the surveyor did not observe the licensee's grievance procedure posted in the facility. On February 3, 2025, at 11:47 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were not aware of the Statute requiring the grievance policy and contact information to be posted.	0 550			

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0 550	Continued From page 11 The licensee's Client-Consumer Grievance Policy dated May 3, 2023, indicated a copy of the policy would be accessible by all client-consumers of the licensee; and the licensee was required to annually document the client had received and understood the policy. The policy failed to indicate the grievance procedure would be conspicuously posted in the facility with the following contact information: name, phone number and email contact for the individuals who were responsible for handling resident complaints; Offices of Ombudsman for Long-Term Care (OOLTC), Mental Health and Developmental Disabilities (OOMHDD), and Minnesota Adult Abuse Reporting Center (MAARC). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 660 SS=D	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.	0 660			

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0 660	Continued From page 12 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB baseline screening for one of two unlicensed personnel ((ULP)-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: The licensee's Facility TB Risk Assessment dated August 20, 2024, identified the facility was at a medium risk for TB transmission. ULP-A was hired on January 29, 2024, to provide direct care to the licensee's residents. ULP-A's Baseline TB Screening Tool for Health Care Workers (HCWs) dated January 29, 2024, indicated ULP-A did not have a history of a positive reaction to a TB skin test (TST) or TB blood test (IGRA), but had an adverse (allergic) reaction to a TST; and ULP-A had received a bacille Calmette-guerin (BCG) vaccine for TB. ULP-A's Baseline TB Screening Tool for Health	0 660			

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0 660	Continued From page 13 Care Workers did not include TB testing by two-step TSTs or IGRA blood test. ULP-A's chest x-ray dated January 23, 2024, indicated a chest x-ray was found to be negative for active TB. The chest x-ray reading did not indicate if there was a prior TST or IGRA that was positive. ULP-A's personnel record lacked documentation of ULP-A refusal to be tested for TB and did not have documentation of a previous positive TST or IGRA. On February 4, 2025, at 12:01 p.m., licensed practical nurse (LPN)-E stated they stopped doing the TSTs due to reactions when the staff had a history of a BCG vaccine in the past and instead, they would just have the staff do a chest x-ray. On February 5, 2025, at 8:57 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated people with a BCG vaccine don't even allow the licensee to do the TB testing and thought an x-ray was sufficient documentation. The licensee's undated Tuberculosis Screening policy indicated employees, volunteers or contact personnel who provided direct care, would have evidence of baseline TB screening that consisted of two components of assessment for current symptoms of active TB disease and testing for the presence of infection with TB by either a two-step TST or a single TB blood test. Also, the policy indicated an employee history of BCG vaccination should be disregarded when administering and interpreting TST results.	0 660			

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0 660	Continued From page 14 Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, on page 10, indicated baseline TB screening was required for all HCW's, and the baseline TB screening would consist of three components: assess for current symptoms of active TB disease; assess TB history; and test for presence of infection with TB by administered two-step TST or single IGRA. On page 14, the document indicated HCW with previous history of severe adverse reaction to TST should not receive the TST but should substitute an IGRA for the TST; and HCW's who refused a TST should be screened using an IGRA. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730			

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0 730	Continued From page 15 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included a signed service plan for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 730			

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0 730	Continued From page 16 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: R2 R2 was admitted on June 28, 2023, with a diagnosis of spinal card injury ((cervical) C5-C7). On February 4, 2025, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. R2's Service Plan with an effective date of February 5, 2025, indicated R2's services included assistance with bathing, catheter care, dressing, drinking, exercise/passive range of motion, grooming, gastrostomy (G-tube) care, housekeeping, irrigation/flush, laundry, linen change, meal assistance, meal reminder, meal tray, medication assist, medication administration, medication setup, and transfer assist. R2's Service Plan was signed by the resident and licensee with a date of July 6, 2023, which was one year, six months, four weeks, and two days prior to the effective date of the service plan. R3 R3 was admitted on May 2, 2023, with diagnoses of diabetes and autism-Asperger's syndrome (neurodevelopmental disorder that affects emotion, communication, and behavioral skills). On February 4, 2025, at 9:06 a.m., the surveyor observed ULP-A assist R3 with medication	0 730			

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0 730	Continued From page 17 administration. R3's Service Plan with an effective date of February 5, 2025, indicated R3's services included assistance with activities, bathing, colostomy changes, dressing, grooming, housekeeping, laundry, meal assistance, meal prep, medication administration, medication set up, skin care, compression stockings, and vital sign monitoring. R3's Service Plan was signed by the resident and licensee with a date of May 20, 2023, which was one year, eight months, two weeks, and two days prior to the effective date of the service plan. On February 4, 2025, at 9:28 a.m., the surveyor interviewed R3. R3 stated they had a written service plan (agreement or contract) that showed what services the provider agreed to provide to R3. On February 5, 2025, at 11:55 a.m., the surveyor asked the licensee if they had any previous signed service plans that were effective prior to February 5, 2025. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they did not have any signed service plans prior to today so [LPN-E] had the residents sign them today. On February 5, 2025, at 12:21 p.m., the surveyor asked the licensee to explain why the service plans indicated an effective date of February 5, 2025, but were signed with a date prior to the effective date of the service plan. LALD/CNS-C stated R2 and R3's service plans were back dated today, for some reason they could not find the signed service plans for these two residents LALD/CNS-C stated the licensee was aware of service plans needing to be signed and it was	0 730			

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0 730	Continued From page 18 done every time. The licensee's undated Service Plan policy indicated the service plan along with any revisions must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. Also, the policy indicated the original service plan and any revised service plans must be entered into the resident record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with egress window requirements in State Fire Code, Minnesota Rules 7511. This had the potential to directly affect two residents and all 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 serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 775	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.		

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0 775	Continued From page 19 has affected or has potential to affect a large portion or all of the residents). The findings include: On February 4, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. The egress windows in resident sleeping rooms were opened by LALD/CNS-C and measured by the surveyor. The egress windows in resident sleeping rooms 1, 2, and 3 did not meet the minimum open width requirements for safe egress. Egress window measurements: Occupied resident sleeping room 1 - the clear open area of both windows measured 19.5 inches width, 36 inches height, with a total clear area of 702 square inches. Occupied resident sleeping room 2 - the clear open area of window 1 measured 19.5 inches width, 36 inches height, with a total clear area of 702 square inches. The clear open area of window 2 measured 19 inches width, 36 inches height, with a total clear area of 684 square inches. Unoccupied resident sleeping room 3 - the clear open area of the window measured 19.5 inches width, 36 inches height, with a total clear area of 702 square inches. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet).	0 775			

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0 775	Continued From page 20 During the facility tour interview on February 4, 2025, LALD/CNS-C verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate Based on observation and interview, the licensee failed to comply with State Fire Code, Minnesota Rules 7511. This had the potential to directly affect all residents, staff, and visitors. The findings include: On February 4, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. During the tour, the surveyor observed the following: 1. One receptacle was missing in the wall outlet in occupied resident room 1. Electrical outlets must be properly installed to protect the building occupants from electrical hazards and to prevent electrical fires. 2. The window blind obstructed the egress window in occupied resident sleeping room 4. Egress windows must be accessible and maintained free of obstruction. 3. An exit sign was posted at the side door and a key only lock was installed on the door 71 inches above the floor. This door was labeled as an exit on the posted upper level floor plan. The use of hardware requiring a key to open the exit door would delay exiting in the event of an evacuation. 4. A plastic bag containing trash had been placed in the smoking material disposal container on the back deck creating a fire hazard. 5. An exit sign was posted above the front door and the area in front of the door was obstructed	0 775			

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0 775	Continued From page 21 by storage. This door was labeled as an exit on the posted upper level floor plan. Emergency exits must be maintained free of obstruction at all times. 6. An orange extension cord was used to supply power in the living room creating a fire hazard. During the facility tour interview on February 4, 2025, LALD/CNS-C verified the above listed observations.	0 775			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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;	0 780			

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NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9737 3RD STREET NE MINNEAPOLIS, MN 55434		
(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
0 780	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide an interconnected smoke alarm in a resident sleeping room. This had the potential to directly affect more than a limited number of 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 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: On February 4, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. During the tour, the surveyor observed the following: 1. The smoke alarm in occupied resident sleeping room 4 in the basement did not work when tested by LALD/CNS-C. LALD/CNS-C removed the smoke alarm from the bracket and a battery was not installed. 2. When LALD/CNS-C tested the smoke alarms, the smoke alarm installed outside resident sleeping rooms 1, 2, and 3 was not actuated. The smoke alarm outside these sleeping rooms was not interconnected with the other dwelling unit smoke alarms as required by statute. During the facility tour interview on February 4, 2025, LALD/CNS-C verified the above listed smoke alarm observations.	0 780			

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0 780	Continued From page 23	0 780			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect more than a limited number of 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 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:	0 800			

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0 800	Continued From page 24 On February 4, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. During the tour, the surveyor observed the following: 1. The cover for the exhaust vent was missing in the basement bathroom. 2. There was a hole in the wall behind the bed in occupied resident sleeping room 1. 3. There was a gap between light switch cover and the wall tile in the main floor resident bathroom. 4. The exterior fence in the backyard had one section that was in disrepair. During the facility tour interview on February 4, 2025, LALD/CNS-C verified the above listed physical environment observations. 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) staff 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.	0 810			

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0 810	Continued From page 25 (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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 February 4, 2025, assisted living director/clinical nurse supervisor (LALD/CNS)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810			

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0 810	Continued From page 26 evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to identify the location and number of resident sleeping rooms evident by the following: - On the lower level FSEP floor plan, the resident sleeping room was not labeled with an identifier. On February 4, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. During the tour, LALD/CNS-C verbally identified this resident sleeping room as 4. - On the upper level FSEP floor plan, the resident sleeping rooms were labeled 1, 2, and 3. A sleeping room identifier was not posted at or on the door for resident sleeping room 1. All resident sleeping rooms are required to be identified and correspond with the floor plan in order to provide efficient communication for exiting in the event of a fire or similar emergency. The FSEP included a fire safety program for the workplace that was a template from a third-party provider and had not been developed for use at this facility. 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 employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. The FSEP fire safety program for the workplace inappropriately directed the building occupants to remain in the building until ordered to move by the fire marshal in a building that did not have any fire resistant construction or life safety systems. The FSEP inaccurately instructed the building occupants to not use the elevator and to pull the	0 810			

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0 810	Continued From page 27 nearest fire alarm. The facility did not have an elevator and pull fire alarms were not installed. The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. 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 evident by no procedures in the plan. During an interview on February 4, 2025, at 1:00 p.m., LALD/CNS-C verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year evident by the lack of training documentation. No employee training records were provided. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of documentation. No resident training records were provided. A blank template titled fire safety training for assisted living residents was provided. During an interview on February 4, 2025, at 1:00 p.m., LALD/CNS-C verified the training frequencies were not met for employees and residents. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire	0 810			

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0 810	Continued From page 28 drill reports lacking the required frequency. Two fire drills had been conducted in the past year, reports were dated May 10, 2024, and October 2, 2024. Both drill reports indicated these drills had combined the AM and PM shift employees. During an interview on February 4, 2025, at 1:00 p.m., LALD/CNS-C stated the licensee combined employee shifts for the fire drills and verified the fire drills were not completed during each shift. LALD/CNS-C verified the drill frequency was not met and stated they did not know a minimum of six drills were required each year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=G	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 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	01290			
			During the survey, the licensee took action		

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01290	Continued From page 29 review, the licensee failed to ensure a background study was conducted prior to staff providing services for one of five unlicensed personnel ((ULP)-B). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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 February 3, 2025, at 9:55 a.m., the surveyor observed ULP-B was the only staff member at the licensee's facility upon the surveyor's arrival to the facility. On February 3, 2025, at 10:08 a.m., ULP-B stated they have worked on and off for the facility for a while just picking up shifts, but recently, they were now scheduled to work every Monday. On February 3, 2025, at 11:50 a.m., the surveyor observed ULP-B feeding R1 in the dining room. ULP-B was hired on October 1, 2019, to provide direct care to the licensee's residents. ULP-B's employee record lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents. On February 3, 2025, at 1:17 p.m., licensed assisted living director/clinical nurse supervisor	01290	to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.		

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01290	Continued From page 30 (LALD/CNS)-C acknowledged ULP-B was not on the licensee's Netstudy roster and stated they believed this employee was underage at the time they were hired for the licensee. The licensee's undated Background Studies policy indicated all employees who provided direct care to residents would have a background study completed; and the employee would not work until the results of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290			
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them;	01370			

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01370	Continued From page 31 (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for two of two unlicensed personnel ((ULP)-A, ULP-D). 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:	01370			

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01370	Continued From page 32 ULP-A ULP-A was hired on January 29, 2024, to provide direct care to the licensee's residents. On February 4, 2025, at 8:59 a.m., the surveyor observed ULP-A assist resident (R2) with medication administration. ULP-A's personnel record lacked evidence of completed training and/or competency testing for the following: - care and use of hearing aides; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. ULP-D ULP-D was hired on March 28, 2023, to provide direct care to the licensee's residents. ULP-D's personnel record lacked evidence of completed training and/or competency testing for the following: - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - care and use of hearing aides; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders;	01370			

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01370	Continued From page 33 - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On February 5, 2025, at 9:07 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated it may have been an oversight as they usually assigned all the required courses in Educare (common online education) The licensee's undated Qualifications, Training and Competency policy indicated unlicensed personnel who provided assisted living services must have successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in the Statute. The policy listed all the required training and competencies topics in Statute. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of	01470			

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01470	Continued From page 34 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01470			

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01470	Continued From page 35 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 observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for two of three unlicensed personnel ((ULP)-A, ULP-D). 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: ULP-A ULP-A was hired on January 29, 2024, to provide direct care to the licensee's residents. On February 4, 2025, at 8:59 a.m., the surveyor observed ULP-A assist resident (R2) with medication administration.	01470			

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(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
01470	Continued From page 36 ULP-A's personnel record lacked evidence of orientation training that included an overview of assisted living statues; handling of resident complaints, reporting of complaints, where to report; consumer advocacy services; review of types of assisted living services the employee would provide and provider's scope of license; and principles of person-centered planning/service delivery. ULP-D ULP-D was hired on March 28, 2023, to provide direct care to the licensee's residents. ULP-D's personnel record lacked evidence of orientation training that included an overview of assisted living statues; handling emergencies and using emergency services; handling of resident complaints, reporting of complaints, where to report; consumer advocacy services; review of types of assisted living services the employee would provide and provider's scope of license; and principles of person-centered planning/service delivery. On February 5, 2025, at 1:33 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated it was an oversight for the orientation and the licensee would do a review of the courses they assigned in Educare (popular online education) to ensure the employees completed the required courses. The licensee's undated Facility Employee Orientation policy indicated all employees would complete an orientation on topics required by Minnesota Statues and Rules for Assisted Living. The Policy had referenced 144A Statues and not 144G Statues for the state required orientation topics.	01470			

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01470	Continued From page 37 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	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 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	01500			

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01500	Continued From page 38 (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 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 annual training included all required topics for each 12 months of employment, for two of two unlicensed personnel ((ULP)-B, ULP-D). 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	01500			

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01500	Continued From page 39 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on October 1, 2019, to provide direct care to the licensee's residents. ULP-B's personnel record lacked evidence of the following required annual training in 2024: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control techniques; and - principles of person-centered planning/service delivery. ULP-D ULP-D was hired on March 28, 2023, to provide direct care to the licensee's residents. ULP-D's personnel record lacked evidence of required annual training in 2024 on Assisted Living Bill of Rights. On February 5, 2025, at 1:33 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated it was an oversight and they would do a review of the courses they assign to staff to ensure they met the required topics. The licensee's undated Annual Training Requirements policy indicated all staff that provided direct care services in assisted living must complete at least eight hours of annual training for each 12 months of employment; and the annual training must include the following: - reporting of maltreatment of adults; - review of Assisted Living Bill of Rights and staff	01500			

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01500	Continued From page 40 responsibilities related to ensuring the exercise and protection of those rights; - infection control techniques used in the home; - 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; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be 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	01620			

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01620	Continued From page 41 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 the registered nurse (RN) completed a comprehensive nursing assessment within the required 90-day timeframe for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 R2 was admitted on June 28, 2023, with a diagnosis of spinal card injury ((cervical) C5-C7). On February 4, 2025, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. R2's Service Plan dated February 5, 2025, indicated R2's services included medication administration. R2's record included 90-day nursing assessments dated May 13, 2024, August 10,	01620			

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01620	Continued From page 42 2024, and November 13, 2024. The assessment completed November 13, 2024, indicated 95 days had passed since the prior assessment completed on August 10, 2024. R3 R3 was admitted on May 2, 2023, with diagnoses of diabetes and autism-Aspergers syndrome (neurodevelopmental disorder that affects emotion, communication and behavioral skills). On February 4, 2025, at 9:06 a.m., the surveyor observed ULP-A assist R3 with medication administration. R3's Service Plan dated February 5, 2025, indicated R3's services included medication administration. R3's record included 90-day nursing assessments dated October 16, 2024, and January 18, 2025. The assessment completed January 18, 2025, indicated 94 days had passed since the prior assessment completed on October 16, 2024. On February 5, 2025, at 1:18 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had a process to ensure the assessments were getting done on time by setting up a reminder date in the electronic medical record. LALD/CNS-C thought this may have been an oversight or error when entering the due dates; or if the assessment due date was on a weekend, then it may have been changed to during the week. LALD/CNS-C stated the assessment could also depend on the mood of the client as they may refuse or if the resident had an appointment that day.	01620			

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01620	Continued From page 43 The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated resident re-assessment and monitoring would not exceed 90 calendar days from the last date of assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures	01790			

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01790	Continued From page 44 regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures, training and competencies for the unlicensed personnel (ULP) who would provide	01790			

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01790	Continued From page 45 medications to residents who had unplanned time away when the licensed nurse was not available for three of three unlicensed personnel ((ULP)-A, ULP-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on January 29, 2024, to provide direct care to the licensee's residents. On February 4, 2025, at 8:59 a.m., the surveyor observed ULP-A assist resident (R2) with medication administration. ULP-A's training record lacked documentation ULP-A was trained and found competent to provide medications to residents who had unplanned times away. ULP-B was hired on October 1, 2019, to provide direct care to the licensee's residents. ULP-B's training record lacked documentation ULP-B was trained and found competent to provide medications to residents who had unplanned times away. ULP-D was hired on March 28, 2023, to provide direct care to the licensee's residents.	01790			

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01790	Continued From page 46 ULP-D's training record lacked documentation ULP-D was trained and found competent to provide medications to residents who had unplanned times away. On February 5, 2025, at 1:05 p.m., the surveyor explained to the licensee 144G.71 subd 10 (a;2-4) (b) Statue. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had misunderstood the requirement of the Statue, and the licensee currently did not have a written process for staff to follow when a resident had an unplanned time away from the facility for scheduled medications, but they would reference their electronic documentation system and policy to correct this. The licensee's undated Medications for a Resident Who Will Be Away from Facility When Medications are Scheduled policy indicated an assisted living facility that provided medication management services for the residents must develop policies and procedures for giving accurate and current medications to residents for planned and unplanned times away from the facility. The policy indicated for unplanned times away when the nurse would not be available, the RN may delegate the task to unlicensed personnel if the RN had trained the unlicensed staff and determined the unlicensed staff competent to follow the procedures for giving medications to residents.; and the RN had developed written procedures for the unlicensed staff that included any special instructions or procedures regarding controlled substances that were prescribed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01790			

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01790	Continued From page 47	01790			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the 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 the current residents, staff and any visitors of the licensee. 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 included: On February 3, 2025, at 9:55 a.m., upon the surveyor's arrival to the facility, the surveyor observed the front entrance had a sign posted that read, please use side door, ring bell, if no answer call 763-951-3329. The surveyor went to	03090			

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03090	Continued From page 48 the side door of the facility and observed a sign posted on the side door that read, please go up the ramp, knock on the door, if no answer call 763-951-3329. The front door and the side door did not have the required notice displaying the statutory language to disclose electronic monitoring activity. On February 3, 2025, at 10:13 a.m., the surveyor observed the back patio door on top of the ramp. The back patio door did not have the required notice displaying the statutory language to disclose electronic monitoring activity. On February 3, 2025, at 12:07 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C acknowledged no electronic monitoring signage was posted at the main entrances to the facility. LALD/CNS-C stated it was an oversight. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 02/03/25
Time: 14:23:36
Report: 1029251025

Food and Beverage Establishment Inspection Report

Page 1

Location:

MN Best Homecare LLC
9737 3rd Street NE
Blaine, MN55434
Ramsey County, 62

Establishment Info:

ID #: 0037821
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6128065003
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 previously issued on 11/07/22 have NOT been corrected.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

11/8/22-2/3/25: FOOD DEBRIS ON INTERIORS OF SOME DRAWERS & CABINETS. GREASE AND FOOD RESIDUE BUILDUP AROUND AND ABOVE RANGE. REP INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.

Issued on: 11/07/22

Comply By: 11/08/22

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.

SHELL EGGS AND RAW SAUSAGE NOT SAFELY SEPARATED FROM READY TO EAT FOODS. SAFE STORAGE PRACTICES DISCUSSED. REP INSTRUCTED TO SAFELY SEPARATE RAW ANIMAL PROTEINS FROM RTE FOODS.

Comply By: 02/03/25

7-200 Toxic Supplies and Applications

7-207.11B

**** Priority 1 ****

MN Rule 4626.1660B Label and locate personal medications in areas that do not contaminate food, equipment, linens, and single-service and single-use articles.

INSULIN STORED IN UNLOCKED FOOD REFRIGERATOR. REP INSTRUCTED TO NOT STORE MEDICATIONS WITH FOODS TO PREVENT POSSIBLE CONTAMINATION.

Type: Full
Date: 02/03/25
Time: 14:23:36
Report: 1029251025
MN Best Homecare LLC

Food and Beverage Establishment Inspection Report

Page 2

Comply By: 02/03/25

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPENED PACKAGES OF DELI MEAT AND SHREDDED CHEESE W/OUT DATE MARKINGS. DATE MARKING AND THE DANGERS OF LISTERIA DISCUSSED WITH REP. REP INSTRUCTED TO DATE MARK REQUIRED ITEMS.

Comply By: 02/03/25

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER ENCRUSTED WITH GREASE AND FOOD DEBRIS. REP INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.

Comply By: 02/04/25

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

PHOTOCOPY OF CFPM CERTIFICATE POSTED. REP INSTRUCTED TO POST ORIGINAL OR DUPLICATE AT A MAXIMUM OF 2 LOCATIONS W/IN 60 MILES OF EACH OTHER.

Comply By: 02/04/25

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

DAMP WIPING CLOTH NOT IN USE AND NOT IN SANITIZER SOLUTION. REP INSTRUCTED TO KEEP WIPING CLOTHS IN SANITIZER SOLUTION WHEN NOT IN USE.

Comply By: 02/03/25

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

FOOD CONTACT SURFACE SANITIZER NOT PRESENT. CHLORINE DISINFECTANT PRESENT BUT MUCH > THAN 200 PPM AND NOT DILUTED. ESTABLISHMENT USUALLY USES MANUFACTURED FOOD CONTACT SURFACE WIPES. REP INSTRUCTED TO OBTAIN WIPES OR SANITIZER W/ TEST STRIPS.

Comply By: 02/04/25

Type: Full
Date: 02/03/25
Time: 14:23:36
Report: 1029251025
MN Best Homecare LLC

Food and Beverage Establishment
Inspection Report

Surface and Equipment Sanitizers

HOT WATER: = at > 150 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COLD HOLD/TOMATO SAUCE
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR DOOR
Violation Issued: No

Process/Item: COLD HOLD/MILK
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR CAVITY
Violation Issued: No

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

KITCHEN RESIDENTIAL IN NATURE. ESTABLISHMENT USES NSF/ANSI STANDARD 184 DISHWASHER TO SANITIZE EQUIPMENT AND UTENSILS.

TOPICS COVERED:

- HIGH HEAT AND CHEMICAL SANITIZING
- TEMPERATURE CONTROL
- PROTECTION FROM CONTAMINATION
- EMPLOYEE ILLNESS LOGGING
- ILLNESS EXCLUSION REQUIREMENTS
- REPORTING REQUIREMENTS
- COMMON FOODBORNE ILLNESS PATHOGENS
- VOMIT/FECAL MATTER CLEANUP PROCEDURE
- DATE MARKING AND L. MONOCYTOGENES
- SEAM DENTS AND BLOATING ON CANS AND C. BOTULINUM
- HIGHLY SUSCEPTIBLE POPULATION
- EMPLOYEE HYGIENE AND HANDWASHING
- GLOVE/UTENSIL USE AND BARE-HAND-CONTACT
- PEST CONTROL

Type: Full
Date: 02/03/25
Time: 14:23:36
Report: 1029251025
MN Best Homecare LLC

Food and Beverage Establishment Inspection Report

Page 4

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 1029251025 of 02/03/25.

Certified Food Protection Manager LYDIA K. NALWOGA

Certification Number: 74077 Expires: 10/28/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

LYDIA NALWOGA
LPN

Signed: Trevor McCliment

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029251025

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, and Lodging Services

625 Robert Street North

St. Paul

No. of RF/PHI Categories Out

4

Date

02/03/25

No. of Repeat RF/PHI Categories Out

0

Time In

14:23:36

Legal Authority MN Rules Chapter 4626

Time Out

MN Best Homecare LLC

Address

9737 3rd Street NE

City/State

Blaine, MN

Zip Code

55434

Telephone

6128065003

License/Permit #

0037821

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

Surpervision

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

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 proceeedures 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 labeled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

X

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

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

X

Non-food contact surfaces clean

X

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:

02/04/25

Inspector (Signature)

Trevor McCliment