Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery
November 17, 2023

Licensee
Care Partners Homecare LLC
6218 Unity Avenue North
Brooklyn Center, MN 55429

RE: Initial License Number 406935
Health Facility Identification Number (HFID) 38680
Project Number(s) SL38680015

Dear Licensee:

On November 13, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the licensing survey completed May 24, 2023, and follow-up survey completed July 17, 2023. The November 13, 2023, follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective November 13, 2023.**

In addition, this is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL PROVISIONAL LICENSE

Electronically Delivered

July 26, 2023

Licensee
Care Partners Homecare, LLC
6218 Unity Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 406935
Health Facility Identification Number (HFID) 38680
Project Number(s) SL38680015-0; SL38680015-1

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on May 24, 2023, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider.

On July 17, 2023, MDH conducted a revisit to follow-up on orders issued pursuant to the initial survey completed on May 24, 2023.

Based on the initial survey and this follow-up survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G.

As a result, per Minn. Stat. § 144G.16, Subd. 3 (b), MDH is extending your provisional license for 90 days and applying conditions necessary to bring the facility to compliance. The conditional provisional license is due to expire on **October 24, 2023**.

CONDITIONAL LICENSE ISSUED:
MDH will issue Care Partners Homecare, LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Care Partners Homecare, LLC is in substantial compliance.

The following condition(s) apply on the provisional conditional assisted living facility license:

a. **Egress window requirements:** Care Partners Homecare, LLC replaced windows in residents sleeping rooms two, three and four with egress windows after the initial survey, and these windows were found to be compliant on the follow-up survey. Care Partners Homecare, LLC must replace the window in resident one's sleeping room with an egress window with an unobstructed opening of at least 20 inches in width before

the end of the conditional license period.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Care Partners Homecare, LLC is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Care Partners Homecare, LLC is in substantial compliance on the follow up evaluation, MDH will remove the condition(s) and grant Care Partners Homecare, LLC's assisted living facility with dementia care license. If MDH determines Care Partners Homecare, LLC is not in substantial compliance, MDH may take additional enforcement action against Care Partners Homecare, LLC, or employ any of the enforcement tools listed in Minn. Stat. § 144G, up to and including denial of license.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

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 Paul Spencer directly at: 651-201-4222.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38680	A. BUILDING: _____ B. WING _____	R 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	6218 UNITY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL38680015-1 On July 17, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on May 24, 2023. At the time of the survey, there were 02 residents: 02 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued. An immediate correction order was identified on July 17, 2023, issued for SL38680015-1, tag identification 0820.	{0 000}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	{0 480}		

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{0 480}	Continued From page 1 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{0 480}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	{0 810}		

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{0 810}	Continued From page 2 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: No further action required	{0 810}		
{0 820} SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedroom # 1 with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident bedroom #1 on the main floor. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	{0 820}	This immediate correction order identified on July 17, 2023, had the immediacy lifted as of July 17,2023. This was confirmed [by the surveyor's on-site observation] and approved by evaluation supervisor, however non-compliance remained at a scope and level of I. .	

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{0 820}	Continued From page 3 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 17, 2023, approximately from 10:30 a.m. to 11:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A. At approximately 10:35 a.m., survey staff entered occupied resident bedroom #1 on the main floor to verify an egress window had been provided. None of the three casement-style windows had been replaced to provide an egress window. The hardware for each window obstructed the window from opening completely and would require special knowledge of the window to be able to disassemble the window hardware to open the window completely. Survey staff explained to LALD-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On July 17, 2023, at approximately 11:00 a.m., at the exit interview, LALD-A stated that he did not	{0 820}		

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{0 820}	Continued From page 4 have a window ordered for bedroom #1 that would meet egress requirements and that the facility had stopped doing the fire watch on June 2, 2023, when the other egress windows were installed. LALD-A stated that he had misunderstood the situation for Bedroom #1 and thought that he only needed to designate one of the three windows as the egress window, but did not understand that he had to replace the window with an egress-compliant window. Survey staff reviewed the previous survey report with LALD-A and saw that he had highlighted the part of the text requiring a compliant egress window in bedroom #1. Survey staff explained to LALD-A that an immediate correction order was issued for the above finding. LALD-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate. On July 19, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	{0 820}		
{01620} SS=D	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.	{01620}		

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{01620}	Continued From page 5 (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: No further action required	{01620}		
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	{01730}		

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{01730}	Continued From page 6 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further action required	{01730}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	{01940}		

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{01940}	Continued From page 7 that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action required	{01940}		

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	38680	A. BUILDING: _____ B. WING _____	05/24/2023

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #SL38680015 On May 22 through May 24, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents receiving services under the provider's Assisted Living license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the survey. The following immediate correction order is issued/orders are issued for #SL38680015, tag identification 0820. On May 25, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	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.	

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0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all three residents residing in the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated May 24, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800		

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0 800	Continued From page 2 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 a facility tour on May 24, 2023, from approximately 1:00 p.m. to 2:00 p.m. with the Licensed Assisted Living Director (LALD)-A it was observed that the egress window in unoccupied resident bedrooms #5 was obstructed from opening by the snow and weather shield installed on top of the window well. The casement style window could not be opened far enough to adjust the snow shield to allow for proper egress.	0 800		

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0 800	Continued From page 3 LALD-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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	38680	A. BUILDING: _____ B. WING _____	05/24/2023

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0 810	Continued From page 4 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 24, 2023, at approximately 2:00 p.m. with the licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During	0 810		

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0 810	Continued From page 5 interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD-A stated the licensee did not have any documented training on training employees. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or	0 810		

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0 810	Continued From page 6 relocation as required by statute. During interview, LALD-A stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that drills were completed on 08.08.2022 AND 03.01.23. During interview, LALD-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 820	On May 25, 2023, the immediacy of	

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0 820	Continued From page 7 failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms # 1, #2, #3, and #4 with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident bedrooms #1, and #2 on the main floor. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 24, 2023, approximately from 1:00 p.m. to 2:00 p.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A. At approximately 1:15 p.m., survey staff opened the windows in occupied resident bedroom #1 on the main floor for measurement. All three of the casement-style windows had measured clear openings of 23 inches in width and 38 inches in height. The hardware for each window obstructed the window from opening completely and would require special knowledge of the window to be able to disassemble the window hardware to open the window completely. Survey staff attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. At approximately 1:25 p.m., survey staff opened	0 820	correction order 0820 was removed, however non-compliance remained at a scope and level of I. I acknowledge the receipt of your email. I will send you a policy at the end of the day that will reflect our plan to remove the immediacy while the window cited are being replaced, which is anticipated to be completed by the weekend. The windows are being replaced today as of the time of this note. To give you an idea, our staff are doing an hourly check to ensure there is no fire and plan to remove residents should there be a fire. Will this be sufficient? I look forward sending you the policy with our plan. Regards, Ishmael Ishmael Komara DNP, MHA, RN, PHN, LALD RN/ Executive Director Care Partners Homecare LLC 8525 Edinbrook Xing North STI 13 Brooklyn Park, MN 55443 Office: 763-777-4229 Ext: 700 Cell: 763-458-2727 Fax: 763-207-0076 Email: ikomara@carepartnersllcmn.com Website: https://carepartnersllcmn.com/	

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0 820	Continued From page 8 the window in occupied resident bedroom #2 on the main floor for measurement. The casement-style window had measured clear openings of 23 inches in width and 38 inches in height. The hardware for each window obstructed the window from opening completely and would require special knowledge of the window to be able to disassemble the window hardware to open the window completely. Survey staff attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. At approximately 1:35 p.m., survey staff opened the window in unoccupied resident bedroom #3 in the basement for measurement. The single-hung style windows had measured clear openings of 33 inches in width and 16 inches in height. At approximately 1:45 p.m., survey staff opened the window in unoccupied resident bedroom #4 in the basement for measurement. The single-hung style windows had measured clear openings of 33 inches in width and 18 inches in height. Survey staff explained to LALD-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On May 24, 2023, at approximately 2:00 p.m., at	0 820	POLICY AREA Emergency Preparedness TITLE OF POLICY 9.07 Fire Watch Policy STATUE/RULE REFERENCE (if any) 144G.45 Subd. 2 EFFECTIVE/REVISED DATE 05/25/2023 POLICY: Fire Watch: A temporary measure intended to ensure continuous and systematic surveillance of the building or portion thereof by one or more Care Partners Homecare LLC residents for the purposes of identifying and controlling fire hazards, detecting early signs of unwanted fire, raising an alarm of fire, removing residents away from fire to a safe place outside of the facility and notifying the fire department and appropriate local, county, and state agencies. In the event of a fire, staff at Care Partners Homecare LLC will assist in protecting and providing safety to the residents, staff and guests. PROCEDURE: 1. Designate a staff each shift to serve as a fire watcher. 2. The staff serving as a fire watcher have the following responsibilities: A. Conduct periodic walk through of the interior of the entire facility every 30 minutes for the purpose of identifying any fire, life or property hazards. B. Document watch activities on a log (attached). C. Maintain a log of fire watch activities on site.	

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0 820	Continued From page 9 the exit interview, survey staff explained to LALD-A that an immediate correction order was issued for the above finding. LALD-A acknowledged the above finding. On May 25, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820	D. Have knowledge of the location and use of the fire extinguishers in the facility. E. In the event of a fire, follow the facility fire procedure.	
01620 SS=D	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	01620		

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01620	Continued From page 10 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 document review and interview, the licensee failed to ensure a registered nurse (RN) completed ongoing resident reassessment and monitoring not exceeding 90 calendar days from the last date of the assessment for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a residents health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes and history of falls. R2's service plan dated September 15, 2022, indicated R2 required assistance with transfers, toileting, dressing, and medication management. R2's assessment dated September 28, 2022, indicated R2 had severe cognitive deficits in memory and orientation. R2's medical record indicated an initial assessment was completed on September 15, 2022, and a 14-day assessment was completed on September 28, 2022. Further review of R2's record did not identify any assessment were completed following the September 28, 2022, assessment.	01620		

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01620	Continued From page 11 During an interview on May 24, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A stated no further assessments were in R2's record. LALD-A stated there should have been a 90-day assessment completed around the end of December 2022 and another 90-day assessment completed around the end March 2023, but there were missed. The licensee 6.02 Assessment Schedules policy, dated August 1, 2021, indicated ongoing resident reassessment and monitoring should be completed as needed based on changes in the needs of the resident but cannot exceed 90 calendar days from the last date of the assessment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730		

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01730	Continued From page 12 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure an individualized medication management plan was completed, to include all required contents for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a residents 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	01730		

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01730	Continued From page 13 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes and history of falls. R2's service plan dated September 15, 2022, indicated R2 required assistance with transfers, toileting, dressing, and medication management. R2's assessment dated September 28, 2022, indicated R2 had severe cognitive deficits in memory and orientation. R2's medication administration record, dated May 2023, indicated R2 received amlodipine by mouth once a day, atropine eye drops at bedtime, benztropine by mouth two times a day, buspirone by mouth three times a day, clonazepam by mouth at bedtime, docusate by mouth one time a day, Dulera inhaler two times a day, fluphenazine injection every two weeks, fluticasone propionate nasal spray one time a day, gabapentin by mouth one time a day, glipizide XL by mouth one time a day, metformin by mouth one time a day, omeprazole by mouth one time a day, polyethylene glycol powder mixed in water two times a day, pravastatin by mouth one time a day, Rybelsus by mouth one time a day, senna by mouth two times a day, vitamin D3 by mouth one time a day, acetaminophen by mouth every four hours as needed, lubricating plus eye drops three times a day as needed, and melatonin by mouth at bedtime as needed. Further review of R2's record did not identify an individualized medication management plan was completed. During interview on May 24, 2023, at 10:30 a.m.,	01730		

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01730	Continued From page 14 licensed assisted living director (LALD)-A agreed the review of medications section on the Uniform Assessment Tool form dated September 15, 2022, did not contain the required information to complete an individualized medication management plan. LALD-A further stated the Individualized Medication Management Plan form the licensee uses was not completed for R2. The licensee's individualized treatment and therapy management plan policy was requested but not received. TIME PERIOD FOR CORRECTION: 7-days	01730		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and	01940		

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01940	Continued From page 15 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure an individualized treatment and therapy management plan was completed, to include all required contents for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a residents health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes and history of falls. R2's service plan dated September 15, 2022, indicated R2 required assistance with transfers, toileting, dressing, and medication management. R2's assessment dated September 28, 2022, indicated R2 had severe cognitive deficits in memory and orientation. R2's order dated December 20, 2022, indicated R2 had ankle foot orthotic (AFO) braces for both	01940		

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CARE PARTNERS HOMECARE LLC	6218 UNITY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 16 ankles to be placed during morning cares and removed at bedtime each day. Further review of R2's record did not identify an individualized treatment and therapy management plan was completed. During interview on May 24, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A agreed the review of treatments section on the Uniform Assessment Tool form dated September 15, 2022, indicated R2 was independent with treatments but had no treatments listed. LALD-A further stated the Individualized Treatment or Therapy Management Plan form the licensee uses was not completed for R2. The licensee's individualized treatment and therapy management plan policy was requested but not received. TIME PERIOD FOR CORRECTION: 7-days	01940		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *05/24/23*
Time: 11:36:59
Report: 7994231108

Food and Beverage Establishment Inspection Report

Location:

Care Partners Homecare LLC
6218 Unity Avenue N
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0041263
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500C 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.

LUNCH MEATS FOUND WITHOUT DATE MARKING. ENSURE THESE ARE MARKED WITH THE DATE THEY ARE OPENED.

Comply By: 05/24/23

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

INSPECTION CONDUCTED AT THE REQUEST OF HRD STAFF AND FINDINGS EMAILED AFTER.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, AND LAMINATE COUNTER TOPS. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

Type: Full
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Care Partners Homecare LLC

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994231108 of 05/24/23.

Certified Food Protection Manager: Tabitha Briggs

Certification Number: 113885 Expires: 11/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994231108

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 05/24/23
Time In 11:36:59
Time Out

Care Partners Homecare LLC	**Address** 6218 Unity Avenue N	**City/State** Brooklyn Center, MN	**Zip Code** 55429	**Telephone**
License/Permit # 0041263	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/24/23

Inspector (Signature) Crystal Elva