Electronically Delivered

October 18, 2024

Licensee
Aspen Care Inc.
3001 84th Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL40133015

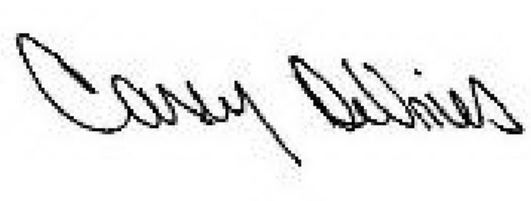
Dear Licensee:

On September 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 21, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Electronically Delivered

July 12, 2024

Licensee
Aspen Care Inc.
3001 84th Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL40133015

Dear Licensee:

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.

The Minnesota Department of Health completed an initial survey on June 21, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40133	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN CARE INC	3001 84TH AVENUE NORTH BROOKLYN PARK, MN 55444

(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(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: SL40133015-0 On June 17, 2024, through June 21 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two (2) residents; 2 receiving services under the provider's provisional Assisted Living license. An immediate correction order was identified on June 18, 2024, issued for SL40133015-0, tag identification 0495. The immediacy of order 0495 was removed on June 20, 2024, however noncompliance remained. 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 18, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week	0 495		

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0 495	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. 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 June 17, 2024, approximately 10:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated he was the only registered nurse employed by licensee at the time of survey and worked at the facility on Tuesdays and Fridays of every week between approximately 9:00 a.m. to 3:00 p.m. CNS-B stated he also worked at a hospital as a float pool nurse working day shifts at a 0.5 (FTE). His shifts at the hospital were rotational, so there were not set days of each week. The licensee's Employee List dated June 17, 2024, indicated CNS-B was the current and only nurse for the licensee. On June 18, 2024, at 12:47 p.m., CNS-B stated he worked at the hospital every other weekend, and his shifts were from 7:00 a.m. to 3:00 p.m.,	0 495		

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0 495	Continued From page 3 on a rotating schedule. The surveyor inquired if CNS-B would be able to answer calls if there was an emergent need and CNS-B stated if he was in the middle of something at the hospital such as a medication pass, he could not take the call until he was done with that task. He also stated he tried to keep his phone close to him at all times. Surveyor asked if he received any calls from the licensee while working at the hospital and he said "not a lot, maybe two calls." CNS-B stated one of the calls was a non-urgent call giving an update about an appointment. On June 18, 2024, at 1:15 p.m., unlicensed personnel/residency permit (ULP/RP)-A stated there was a situation when R2 went missing for a long period of time and when R2 returned to the facility around 8:00 p.m., CNS-B was available shortly after to perform an RN assessment post incident. There was another time when she called CNS-B and CNS-B texted her back asking if it was an emergency, if not, he would call her back. ULP/RP-A stated there had never been a situation where he wasn't available to answer the call during an urgent situation. The licensee's Position Description-Clinical Nurse Supervisor signed by CNS-B on September 2, 2023, under "Essential job functions and tasks," indicated CNS-B was willing to carry a cell phone and be 'on call' for emergencies, resident change of condition, and when ULPs perform delegated nursing tasks. The licensee's 6.12 Availability of an RN for Staff policy effective date June 21, 2023, indicated the RN must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services. The on-call licensed health professional shall respond and	0 495		

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0 495	Continued From page 4 provide consultation to the ULP in a timely manner based on the communicated information. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy of order 0495 was removed on June 20, 2024, however noncompliance remained. The scope and level remain unchanged.	0 495		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside in the immediate vicinity of all sleeping rooms in the facility. This had the potential to affect 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 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). Findings include: On a facility tour on June 18, 2024, at 11:35 a.m., with unlicensed personnel/ residency permit (ULP/RP)-A, it was observed that smoke alarms were not provided inside unoccupied resident sleeping rooms number 3 and 5. All dwelling units are required to be provided with smoke alarms inside the sleeping rooms and interconnected with all other alarms installed in the facility so activation of one alarm activates all alarms throughout the facility. During the tour ULP/RP-A, stated she did not know the alarms were required to be installed inside the unoccupied resident rooms. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780		

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0 800	Continued From page 6	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 18, 2024, at 11:40 a.m., with unlicensed personnel/ residency permit (ULP/RP)-A, the surveyor made the following observations of facility disrepair: The garage side of the fire-resistant wall separating the garage from the assisted living	0 800		

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0 800	Continued From page 7 had a long vertical portion of the required minimum ½" drywall missing near the swinging door leading to the ramp/ walkway to the back yard. Damage to the same drywall membrane was also observed with a hole through the drywall near the swinging door leading to the ramp/ walkway to the back yard and in the middle of the wall near the floor. The fire-resistant wall separating the assisted living from the garage is required to be maintained with a minimum ½" drywall installed and sealed on the garage side of the wall. There was caulking sealant coming off at the base of the wall and floor in the shower in the basement bathroom. The caulking is required to be maintained in place to prevent water from entering the wall cavity and causing water damage. There were cigarette butts observed in the rock landscaping away from the building and on the front step next to the appropriate cigarette dispenser. Used cigarette butts are required to be disposed in the appropriate dispenser and not on the ground around the facility in accordance with the facility smoking policy. A puddle of water was observed on the floor in the storage space under the basement stairway. There was also water damage on the lower 1 foot of the drywall on the walls around the inside of the same closet under the basement stairs. Construction debris was observed in the back yard outside the basement patio door. Several bricks were observed outside on the ground around the front main exit door. During a facility tour on June 18, 2024, at 12:05	0 800		

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0 800	Continued From page 8 p.m., ULP/ RP-A, verified the above listed observations while accompanying on the tour and stated she would contact the building owner to repair the drywall and remove the construction debris. 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	0 810		

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0 810	Continued From page 9 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, make the plan readily available, 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 June 18, 2024, at 11:00 a.m., unlicensed personnel/ residency permit (ULP/RP)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The location and number of resident sleeping	0 810		

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0 810	Continued From page 10 rooms were not included on the evacuation floor plan. The resident room numbers were also not installed on the doors of resident room number 3, 4 and 5. The resident room numbers are required to be included on the evacuation floor plan and on the resident room doors in order to provide direction to occupants for exiting in the event of a fire or similar emergency. During an interview on June 18, 2024, at 11:35 a.m., ULP/ RP-A stated she did not know the numbers were not on the evacuation floor plan and did not think they were required on resident room 3, 4 and 5 because the rooms were not occupied. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=D	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;	01370		

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01370	Continued From page 11 (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: Based on interview and record review, the licensee failed to ensure training was completed for all required areas, prior to providing services, for one of one employee (unlicensed personnel/ residency permit (ULP/RP)-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) 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:	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40133	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN CARE INC	3001 84TH AVENUE NORTH BROOKLYN PARK, MN 55444

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01370	Continued From page 12 ULP/RP-A was hired on August 21, 2023, and began providing direct care services to the licensee's assisted living residents on September 5, 2023. ULP/RP-A's training record lacked competency in the following required area: -standby assistance techniques and how to perform them. On June 18, 2024, at 2:13 p.m., ULP/RP-A stated her understanding of standby assistance techniques was to be available to the resident for their safety, such as fall prevention while showering. She was unsure if clinical nurse supervisor (CNS)-B checked for competency on standby assistance techniques. On June 21, 2024, at 10:03 a.m., and 10:48 a.m., the surveyor attempted to contact clinical nurse supervisor (CNS)-B and was unavailable to be interviewed. The licensee's 6.14 Delegation of Assisted Living Services policy dated June 21, 2023, indicated when the registered nurse or licensed health professional at [licensee] delegates tasks to ULP, that person will ensure that prior to the delegation the ULP is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40133	A. BUILDING: _____ B. WING _____	06/21/2024

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ASPEN CARE INC	3001 84TH AVENUE NORTH BROOKLYN PARK, MN 55444

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01940	Continued From page 13	01940		
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 (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 observation, interview, and record review, the licensee failed to develop and implement an individual treatment or therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40133	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 14 management plan (ITTMP) to include all required content for one of one resident (R1) on oxygen therapy. 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 June 17, 2024, at 2:23 p.m., the surveyor observed unlicensed personnel/residency permit (ULP/RP)-A complete medication administration and provide frequent reminders for R1 to put her oxygen back on. R1 was admitted to the licensee on September 5, 2023. R1's diagnoses included schizoaffective disorder (a mental health disorder), chronic obstructive pulmonary disease (COPD), and sleep apnea (interrupted breathing during sleep). R1's registered nurse assessment dated May 30, 2024, under "Respiratory Equipment;" indicated staff would titrate oxygen level up to 5 liters per nasal cannula (tube delivers oxygen to nose) and to remind resident to always keep nasal cannula on. The assessment also indicated staff to remind resident not to smoke close to the oxygen tank. R1's Service Plan-Modification signed on September 15, 2023, indicated R1 received the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40133	A. BUILDING: _____ B. WING _____	06/21/2024

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01940	Continued From page 15 following services, personal cares, laundry, meals, behavior management, medication administration, respiratory equipment care, and oxygen therapy management. R1's provider orders electronically signed November 30, 2023, indicated R1 required use of continuous oxygen at five liters of oxygen per minute (LPM) via nasal cannula. R1's Service Recap Summary-Month dated June 1, 2024, through June 18, 2024, documented R1 received oxygen delivery on AM, PM, and overnight every day. R1's medical record lacked an ITTMP to include the following content regarding oxygen tubing replacement: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received. On June 21, 2024, at 11:03 a.m., ULP/RP-A stated the oxygen supply company came out every 90 days to do maintenance on R1's oxygen concentrators. Regarding oxygen tubing and nasal cannula, ULP/RP-A changed them every 2 weeks and more often as needed but there were no provider orders on how often they should be replaced so she used common sense. ULP/RP-A	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 16 stated she did not document when she replaced the oxygen tubing and nasal cannula. On June 21, 2024, at 10:03 a.m., and 10:48 a.m., surveyor attempted to contact clinical nurse supervisor (CNS)-B and was unavailable to be interviewed. The licensee's 7.05 Treatments & Therapy Management Plan dated June 21, 2023, indicated licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; -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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

DEPARTMENT OF HEALTH

Type: Full
Date: *06/18/24*
Time: 11:14:06
Report: 1036241119

Food and Beverage Establishment Inspection Report

Location:

Aspen Care Inc
3001 84th Ave North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:

ID #: N043067
Risk:
Announced Inspection: No

License Categories:

,

Expires on: / /

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.

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

OBSERVED A SECONDARY SPRAY BOTTLE WITH NO LABEL. PER STAFF, SOLUTION WAS BLEACH/WATER SANITIZER MIXTURE. ISSUE CORRECTED ON SITE.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

UTENSIL SURFACE TEMP: = at 178 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 36 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -2 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

Type: Full
Date: *06/18/24*
Time: 11:14:06
Report: 1036241119
Aspen Care Inc

Food and Beverage Establishment Inspection Report

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS ANNA BOHNEN. INSPECTION CONDUCTED IN PRESENCE OF KOWSAR SHAFIE, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- SANITIZER USE/TEST KITS
- THERMOMETER USE AND CALIBRATION
- PEST CONTROL
- DATE MARKING
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER

**IF ANY RESIDENTS COMPLAIN OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036241119 of 06/18/24.

Certified Food Protection Manager KOWSAR S. SHAFIE

Certification Number: FM117903 Expires: 06/22/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
KOWSAR SHAFIE
PERSON IN CHARGE (PIC)

Signed: _____
Jeff Johanson