Electronically Delivered

April 21, 2023

Licensee
Cozy Baraka Home Care Inc
9317 Northwood Parkway
New Hope, MN 55427

RE: Project Number(s) SL37402015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 5, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37402	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COZY BARAKA HOME CARE INC	9317 NORTHWOOD PARKWAY NEW HOPE, MN 55427

(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: SL37402015-0 On April 3, 2023, through April 5, 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, the licensee had no residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 dicharged from licensee March 24, 2023. R1's Individual Abuse Prevention Plan (IAPP) dated March 9, 2023, indicated R1 was not at risk to be abused.	0 630		

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0 630	Continued From page 2 R1's IAPP failed to include if R1 was a risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for one of one resident. On April 5, 2023, at 11:30 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated R1's IAPP should include the missing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and	0 650		

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0 650	Continued From page 3 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented a competency for the delegation of medication administration for one of one employee (unlicensed personnel (ULP-C)). In addition, the licensee failed to ensure the employee record included current job description and annual performance review for one of one employee (registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C started work at the licensee's facility on September 21, 2022. ULP-C's employee record included a Knowledge Assessment Medication Administration - Overview completed on October 23, 2022. R1's Medication Administration Summary for January 2023, indicated ULP-C administered medications to R1 on various dates throughout the month of January. On April 5, 2023, registered nurse/licensed	0 650		

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0 650	Continued From page 4 assisted living director (RN/LALD)-A stated ULP-C was trained, and had a competency completed by a RN. RN-B RN-B began employment with the licensee on May 21, 2022. RN-B's employee record lacked the required job description and annual performance review. On April 5, 2023, RN/LALD-A stated RN-B's employee record lacked the required content. Licensee's Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated licensee will "instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 5 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of one employee (registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment worksheet dated May 25, 2022, indicated the licensee's setting was a low risk for TB. RN-B was hired on May 21, 2022. RN-B's record included a TB history and symptom screen dated August 12, 2022, a negative chest x-ray dated February 24, 2017,	0 660		

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0 660	Continued From page 6 and TB training record dated July 20, 2022. RN-B's employee record lacked documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test or documentation of refusal of both the two-step TST and IGRA completed prior to the chest x-ray. On April 5, 2023, at 2:30 p.m., during the exit conference, registered nurse/licensed assisted living director (RN/LALD)-A stated RN-B's record lacked included the documents above. RN/LALD-A stated licensee was not aware of the requirement. Licensee's Tuberculosis Screening policy dated August 1, 2021, indicated licensee will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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0 680	Continued From page 7 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 680		

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0 680	Continued From page 8 The licensee's undated EP plan lacked the following content: - Establishment of the Emergency Program (EP); - Develop and Maintain EP Program; - Maintain and Annual EP Updates; - Process for EP Collaboration; - Development of EP Policies and Procedures; - Subsistence Needs for Staff and Patients; - Procedures for Tracking of Staff and Patients; - Policies and Procedures Including Evacuation; - Policies and Procedures for Sheltering; - Policies and Procedures for Medical Documents; - Policies and Procedures for Volunteers; - Arrangement with Other Facilities; - Roles under a Waiver Declared by Secretary; - Development of Communication Plan; - Names and Contact Information; - Emergency Officials Contact Information; - Primary/Alternate Means for Communication; - Methods for Sharing Information; - LTC Family Notifications; - Emergency Prep Training and Testing; - Emergency Prep Training Program; - Emergency Prep Testing Requirements; - LTC Emergency Power (Typically ENGININEERING); and - Integrated Health Systems. On April 5, 2023, at 11:15 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated the licensee's EP plan was missing required information. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "it is the intent that [licensee] to have in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers	0 680		

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0 680	Continued From page 9 for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN Statute. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to	0 790		

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0 790	Continued From page 10 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 April 4, 2023, at approximately 3:00 p.m., survey staff toured the facility with the Assisted Living Director (LALD)-A. It was observed that the fire extinguisher did not have a service tag showing that it had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. This deficient condition was verified by LALD-A accompanying the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	0 910		

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0 910	Continued From page 11 Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This had the potential to affect all residents of the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's record included a signed Resident Agreement dated March 9, 2023. R1's Resident Agreement lacked documentation of the Health Facility Identification (HFID) number of the facility in a conspicuous place and manner. On March 5, 2023, at 12:30 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated she thought the HFID number was on resident agreement and would update the contract to meet statute requirement. The licensee's Assisted Living License Resource Manual policy for signing an assisted living contract dated August 01, 2021, indicated legal name and license number of the building are required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		

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0 990 SS=F	144G.52 Subd. 2 Prerequisite to termination of a contract (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (d) In the event of an emergency relocation under	0 990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37402	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COZY BARAKA HOME CARE INC	9317 NORTHWOOD PARKWAY NEW HOPE, MN 55427

(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
0 990	Continued From page 13 subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a pre-termination meeting was held seven days prior to issuing a notice of termination for one of one resident (R1) with services terminated. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record lacked evidence the licensee conducted the required meeting with the resident or resident's representative at least seven days before the proposed termination. R1's Discharge Note dated March 25, 2023, indicated R1 was discharged from licensee's (37402) location due to safety concerns and personal preferences. The note further indicated licensed assisted living director coordinated the discharge with R1's case worker, but there was no further documentation.	0 990		

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	37402	A. BUILDING: _____ B. WING _____	04/05/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 990	Continued From page 14 On April 5, 2023, at 11:29 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated R1's transfer was necessitated due to lack of streetlights as R1 liked to ride his scooter late in the night to go to the shopping center. RN/LALD-A further verified the licensee failed to conduct the required pre-termination meeting at least seven days before the proposed termination of services. Licensee's Contract Termination policy dated August 1, 2021, indicated licensee will issue a pre termination meeting notice, in writing to the resident and the resident's representatives at least five (5) business days in advance of the scheduled meeting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 990		
01040 SS=F	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written	01040		

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	37402	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COZY BARAKA HOME CARE INC	9317 NORTHWOOD PARKWAY NEW HOPE, MN 55427

(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
01040	Continued From page 15 termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice of termination for one of one resident (R1). In addition, the licensee failed to send a copy of the termination notice to the Office of Ombudsman for Long-Term Care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record lacked evidence the licensee issued a written notice of termination. R1's Discharge Note dated March 25, 2023,	01040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01040	Continued From page 16 indicated R1 was discharged from licensee's (37402) location due to safety concerns and personal preferences. The note further indicated licensed assisted living director coordinated the discharge with R1's case worker, but there was no further documentation. On April 5, 2023, at 11:29 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated licensee did not do any termination notices. RN/LALD-A also stated licensee did not send any notice of termination to the Ombudsman's office. Licensee's Contract Termination policy dated August 1, 2021, indicated licensee will issue a pre termination meeting notice, in writing to the resident and the resident's representatives at least five (5) business days in advance of the scheduled meeting. The policy further indicated "facility providing a notice to the ombudsman will provide the notice as soon as practicable, but in any event no later than two (2) business days after the facility provided notice to the resident". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01040		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must	01530		

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COZY BARAKA HOME CARE INC	9317 NORTHWOOD PARKWAY NEW HOPE, MN 55427

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01530	Continued From page 17 have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for two of two employees (registered nurse (RN)-B, and unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01530		

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01530	Continued From page 18 The licensee held a current Assisted Living Facility (ALF) license effective May 5, 2022, through April 30, 2023. RN-B started employment with licensee May 21, 2022. RN-B's transcript indicated RN-B had completed the following dementia related online courses: - Dementia - activities - a balance approach - 0.75 hours - Dementia Communication overview - 1 hour; - Dementia problem solving - 0.75 hours; - Dementia 4 behaviors verses symptoms - 1 hour; - Dementia 5 - the journey - 0.75 hours; RN-B's employee record included a total of 4.25 hours for dementia training. The record lacked at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date. ULP-C started employment with licensee August 21, 2022. ULP-C's transcript indicated ULP-C had completed the following dementia related online courses: - Dementia - activities - a balance approach - 0.75 hours - Dementia Communication overview - 1 hour; - Dementia problem solving - 0.75 hours; - Dementia 4 behaviors verses symptoms - 1 hour; - Dementia 5 - the journey - 0.75 hours; ULP-C's employee record included a total of 4.25 hours for dementia training. The record lacked at	01530		

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01530	Continued From page 19 least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. On April 5, 2023, at 11:52 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated RN-B's and ULP-C's employee records were missing at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours, or 160 working hours, respectively, of the employment start date. RN/LALD-A in addition stated licensee thought the required number of hours was four. The licensee's Dementia Training policy dated August 1, 2021, indicated supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. In addition policy indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01940 SS=F	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	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 20 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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01940		

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01940	Continued From page 21 The findings include: R1 started services with the licensee on March 9, 2023. R1's diagnoses included chronic obstructive pulmonary disease (COPD) (a type of progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), seizure disorder, morbid obesity, and anxiety. R1's Service Plan (Wavier)- Addendum to Contract dated March 21, 2023, indicated R1 received assistance with oxygen delivery, non-medical transportation, housekeeping, laundry, and medication administration. R1's treatment or therapy management plan lacked the following content related to the treatment of oxygen delivery: - 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, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On April 4, 2023, at 12:45 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated R1's medical record lacked	01940		

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01940	Continued From page 22 an individualized treatment or therapy management plan to include all the content above. RN/LALD-A stated the nurse completing the assessment did not go through the whole form during assessment which included a treatment management plan. The licensee's Treatments & Therapy Management Plan policy dated August 1, 2021, indicated each resident receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *04/12/23*
Time: 14:54:38
Report: 7994231080

Food and Beverage Establishment Inspection Report

Location:
Cozy Baraka Home Care
9317 Northwood Parkway
New Hope, MN55427
Hennepin County, 27

Establishment Info:
ID #: 0038930
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122429073
ID #:

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

No NEW orders were issued during this inspection.

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

THIS FACILITY CURRENTLY DOES NOT HAVE ANY RESIDENTS.

THE KITCHEN IS A RESIDENTIAL KITCHEN WITH CABINETS ON 6-8INCH LEGS, SMOOTH CEILING, DESIGNATED HANDWASH SINK AND A SANITIZING DISHWASHER.

DISCUSSED WITH OWNER ABOUT THE REQUIREMENTS FOR SAME DAY SERVICE AS WELL AS CURRENT SUGGESTIONS FOR STORING STAFF AND RESIDENTS FOOD.

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 7994231080 of 04/12/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

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

Report #: 7994231080

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	0	**Date**	04/12/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	14:54:38
Legal Authority MN Rules Chapter 4626		**Time Out**	

Cozy Baraka Home Care	**Address** 9317 Northwood Parkway	**City/State** New Hope, MN	**Zip Code** 55427	**Telephone** 6122429073
License/Permit # 0038930	**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:** 04/12/23

Inspector (Signature) Crystal Elva