DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 30, 2022

Administrator
Brask Haven Inc
31274 Julliard Street Northeast
North Branch, MN 55056

RE: Project Number(s) SL30796015

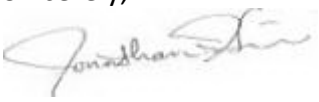
Dear Administrator:

On November 22, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 6, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

Electronically Delivered

September 26, 2022

Administrator
Brask Haven Inc
31274 Julliard St Northeast
North Branch, MN 55056

RE: Project Number(s) SL30796015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 26, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests 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

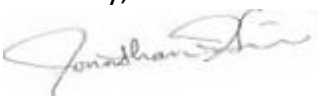
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



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Health Regulation Division
State Evaluation Team
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P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-592-5119 Fax: 651-215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30796	A. BUILDING: _____ B. WING _____	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRASK HAVEN INC	31274 JULLIARD ST NE NORTH BRANCH, MN 55056

(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 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: SL30796015 On, August 22 through August 23, 2022, 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 ten (10) residents receiving services under the provider's 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 Home Care/Assisted Living License 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 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 surveyors ' 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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

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0 480	Continued From page 1	0 480		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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. The facility also failed to ensure food menus were prepared and made available for residents no less than one week in advance. This had the potential to affect all residents of the assisted living 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) 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).	0 480		

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0 480	Continued From page 2 The findings include: On August 22, 2022, at 12:05 p.m., ULP-D stated they did not have a calendar for planned meals, only a calendar where they logged meals already served. On August 22, 2022, at 12:20 p.m., ULP-B asked R4 if he would like lunch. R4 asked what was prepared and ULP-B stated "tator-tot hotdish". R4 stated he thought they were having something else and declined the meal. On August 22, 2022, at 12:22 p.m., R4 stated he never knew what the meal will be ahead of time. He had to ask what the meals would be. R4 stated they did write meals on the refrigerator each day, but was blank today. On August 22, 2022, at 12:24 p.m., main floor white refrigerator was observed and had spaces to write in the meals that indicated, "breakfast:", "lunch:", and "dinner:"; the spaces were blank. On August 22, 2022, at 1:10 p.m., R1 stated he had never been given a menu with future planned meals. R1 stated he had never been included with meal planning or been asked what he liked. R1 stated they did post the food menu for the day on the refrigerator outside of his room but was not always done. R1 looked out of his bedroom door and acknowledged the meals were not written on the refrigerator for the day. On August 22, 2022, at 1:40 p.m., ULP-D stated they did not have a menu which was prepared in advance. ULP-D stated they posted meals on the refrigerator each day so residents know what will be served. ULP-D stated they did not formally	0 480		

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0 480	Continued From page 3 include residents in meal planning but did ask them what they like. On August 22, 2022, at 2:29 p.m., assisted living director (ALD)-C and registered nurse (RN)-A acknowledged menus were not posted in advance, only daily on the refrigerator. The licensee's Menu Planning policy, undated, indicated, "Menus are planned and made available one week in advance in accordance with the minimum requirements of Minnesota Statute Chapter 144G, Assisted Living." Please also refer to the included document titled, Food and Beverage Establishment Inspection Report, dated August 22, 2022, for additional specified Minnesota Food Code deficiencies. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 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;	0 680		

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0 680	Continued From page 4 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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 develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all ten (10) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 23, 2022, the licensee's EP plan was requested. Assisted living director (ALD)-C provided a binder that contained several policies, but did not address the emergency procedures specific to the facility and it's residents.	0 680		

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0 680	Continued From page 5 The licensee lacked an EP plan to include the following: - establish and maintain a comprehensive EP, reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - risk assessment with documentation; - consider duration of interruptions; - consider emerging infectious disease (EIDs); - arrangements/contracts to re-establish utility services; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - missing resident plan; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop and implement EP policies/procedures and review/update annually; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - food, water, medical supplies,	0 680		

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0 680	Continued From page 6	0 680		

pharmaceutical supplies;
- alternate sources of energy to maintain temperature, safety and sanitary storage of provisions, emergency lighting;
- alternate sources of energy to fire detection, extinguishing, alarms systems;
- sewage and waste disposal;
- a tracking system used to document locations of residents, staff, and relocation of staff;
- develop policies and procedures to address safe evacuation from the facility including:
- needs of evacuees;
- staff responsibilities;
- transportation;
- evacuation location;
- alternate communication means;
- develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility;
- develop policy and procedures to address:
- systems of medical documentation that preserve resident information;
- protects confidentiality;
- secures/maintains availability of records;
- develop policy and procedures must address use of volunteers including process and role for integration;
- develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided;
- develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135;
- develop a written communication plan and review/update annually;
- communication plan must include all the following names/contact information:
- staff;
- entities providing services under agreement;

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0 680	Continued From page 7 - residents' physicians; - other facilities; - volunteers; - communication plan must include contact information for: - Federal, State, tribal, regional, and local EP staff; - State Licensing and Certification Agency; - MN Office of Ombudsman for LTC; - other sources of assistance; - communication plan must include; - method for sharing information and medical documentation for residence; - means, in event of evacuation, to release resident information; - means of providing information about general condition and location of residents under [licensee's] care; - communication plan must include: - means to provide information about facility occupancy; - needs; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include A method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually; - training program must include initial EP training to policies and procedures to all new and existing staff and volunteers; - provide EP training at least annually; - maintain documentation of EP training; - demonstrate staff knowledge of EP; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power	0 680		

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0 680	Continued From page 8 systems based on their EP; - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate; On August 23, 2022, at 12:15 p.m., ALD-C acknowledged the licensee had not developed an EP. ALD-C indicated they were busy with other requirements as well as staffing issues, and had not been able to address the appendix Z requirements. The licensee's Emergency and Disaster Preparedness policy, reviewed on February 5, 2022, indicated: 1. A hazard vulnerability assessment (HVA) has been completed to identify the most probable emergency situations that may be experienced by this facility or community. 2. An assisted living facility with dementia care that has a secured dementia care unit must include in their hazard vulnerability assessment a safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; 3. Based on the HVA, an Emergency Preparedness Plan has been developed. 4. The Emergency Preparedness Plan addresses the following requirements: (a) It is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (b) Includes strategies for addressing emergency events identified by the risk assessment. (c) Addresses our resident population, including, but not limited to, persons at-risk; the	0 680		

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0 680	Continued From page 9 type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. (d) Includes a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency. (e) The emergency disaster plan contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency. 5. A written Communication Plan is complete that addresses the elements listed in 42 C.F.R. §483.73(c). 6. Our facility has developed and implements emergency preparedness policies and procedures in compliance with 42 C.F.R. §483.73(c). 7. A written policy and procedure regarding missing residents is complete in compliance with MN Rule 4659.0110. 8. The facility will post the emergency disaster plan prominently. 9. The facility provides building emergency exit diagrams to all residents. 10. Emergency exit diagrams are posted on each floor. 11. Training and Exercises. (a) The facility provides training in emergency and disaster preparedness policies and procedures to all staff during the initial staff orientation and annually thereafter and makes 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.	0 680		

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0 680	Continued From page 10 (b) Training is provided to individuals providing services under arrangement, and volunteers, consistent with their roles. (c) The facility conducts exercises to test the Emergency Preparedness Plan at least twice per year in compliance with 42 C.F.R. §483.73(d)(2). 12. The emergency operations plan, communications plan, and the policies and procedures listed above will be reviewed and updated at least annually. No further information provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	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	0 780		

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	30796	A. BUILDING: _____ B. WING _____	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRASK HAVEN INC	31274 JULLIARD ST NE NORTH BRANCH, MN 55056

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0 780	Continued From page 11 (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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in each sleeping room, failed to provide smoke alarms immediately outside each sleeping area, and failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. 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 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 residents). The findings include: On August 22, 2022, between 11:30 a.m. and 1:00 p.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed the following: 1. Bedrooms 1-4 were accessed from the dining room. There was no smoke alarm in the dining room. The dining room is required to have a smoke alarm due to being outside each separate sleeping area in the immediate vicinity of bedrooms. The only other smoke alarm on the	0 780		

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0 780	Continued From page 12 main level was located in the living room which was separated from the dining room by a deep bulkhead. 2. The bedroom located upstairs did not have a smoke alarm inside or outside in the immediate vicinity. 3. When tested, the smoke alarms were not interconnected. RN-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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.	0 800		

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0 800	Continued From page 13 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 residents). The findings include: On August 22, 2022, between 11:30 a.m. and 1:00 p.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed the following: 1. Bedrooms #2 had excessive lint and dust build up on the exhaust fan in the bathroom. 2. Bedrooms #3 had excessive lint and dust build up on the exhaust fan in the bathroom. 3. Bedrooms #4 had excessive lint and dust build up on the exhaust fan in the bathroom. 4. Bedroom #6 had recent work done to the bathroom ceiling near the exhaust fan. The exhaust fan was not working at time of survey. 5. Bedroom #7 had water damage on the ceiling in the bathroom adjacent to the exhaust fan and a large stain on the carpet from an unknown substance. 6. Bedroom #8 had a large portion of the ceiling in the bathroom removed. RN-A stated they did not know about the large hole, but assumed it was for work being done to the plumbing above. There was no known or documented timeline for starting or finishing the work.	0 800		

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0 800	Continued From page 14 7. A large propane gas grill was being stored on the concrete patio directly under the wood deck at the front of the house. RN-A stated the residents occasionally used the grill but don't move it out from under the deck. 8. The shared bathroom located next to bedroom #5 had a slow leak at the toilet and was continuously running at time of survey. RN-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 810		

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0 810	Continued From page 15 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 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to 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 the potential to affect a large portion or all residents). The findings include: On August 22, 2022, between 11:30 a.m. and	0 810		

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0 810	Continued From page 16 1:00 p.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed evacuation plans were only posted in resident bedrooms and there were none posted in any of the public spaces. RN-A verbally confirmed survey staff observations during the facility tour. During interview on August 22, 2022, at 1:00 p.m., assisted living director (ALD)-C and RN-A, stated the facility had done one training on fire safety and evacuation for their staff, but they had not offered any training on fire safety and evacuation to the residents and had not completed any of the required evacuation drills. Review of the fire policy showed the following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility. 2. No record of required employee evacuation drills. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. An employee record showed one training on fire safety and evacuation had been completed in the last twelve months.	0 810		

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0 810	Continued From page 17 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.	0 900		

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0 900	Continued From page 18 (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with 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). The findings include: R1 was admitted March 14, 2022, and received services including assistance with meals, housekeeping, laundry, transfers, ambulation, blood glucose monitoring and medication management. R1's Service Plan, dated March 14, 2022, included the assisted living contract terms. The contract lacked terms concerning provision of housing.	0 900		

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0 900	Continued From page 19 On August 22, 2022, at 2:23 p.m., assisted living director (ALD)-C stated the contract included in the residents' Service Plan was the same as was used by the previous owners. ALD-C verified that was the contract they used for new admits. ALD-C further stated they provided all existing residents a new copy of that contract in response to the new Assisted Living Licensure. ALD-C indicated they have a new contract to use, but had not implemented it yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;	0 930		

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0 930	Continued From page 20 (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1). 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 of the residents). The findings include: R1 was admitted March 14, 2022, and received services including assistance with meals, housekeeping, laundry, transfers, ambulation, blood glucose monitoring and medication management. R1's Service Plan, dated March 14, 2022, included the assisted living contract terms. The contract lacked: -clear and conspicuous notice of: 1. the right under section 144G.54 to appeal the termination of an assisted living contract; 2. the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; 3. contact information for the Office of Ombudsman for Long-Term Care, and the	0 930		

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0 930	Continued From page 21 Ombudsman for Mental Health and Developmental Disabilities On August 22, 2022, at 2:23 p.m., assisted living director (ALD)-C stated the contract included in the residents' Service Plan was the same as was used by the previous owners. ALD-C verified that was the contract they used for new admits. ALD-C further stated they provided all existing residents a new copy of that contract in response to the new Assisted Living Licensure. ALD-C indicated they have a new contract to use, but had not implemented it yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting	0 940		

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0 940	Continued From page 22 payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1). 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 of the residents). The findings include: R1 was admitted March 14, 2022, and received services including assistance with meals, housekeeping, laundry, transfers, ambulation,	0 940		

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0 940	Continued From page 23 blood glucose monitoring and medication management. R1's Service Plan, dated March 14, 2022, included the assisted living contract terms. The contract indicated, "We are not Medicare certified, but we do participate and accept Elderly Waiver Program. There are public funds available for the service we provide based on eligibility requirements," but lacked: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; (vii) a description of the rent requirements for people who are eligible for medical assistance	0 940		

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0 940	Continued From page 24 waivers but who are not eligible for assistance through the housing support program; -the toll-free phone number for the Minnesota Adult Abuse Reporting Center. On August 22, 2022, at 2:23 p.m., assisted living director (ALD)-C stated the contract included in the residents' Service Plan was the same as was used by the previous owners. ALD-C verified that was the contract they used for new admits. ALD-C further stated they provided all existing residents a new copy of that contract in response to the new Assisted Living Licensure. ALD-C indicated they have a new contract to use, but had not implemented it yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated	0 950		

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BRASK HAVEN INC	31274 JULLIARD ST NE NORTH BRANCH, MN 55056

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0 950	Continued From page 25 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative 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 the residents). The findings include: R1 was admitted March 14, 2022, and received services including assistance with meals, housekeeping, laundry, transfers, ambulation, blood glucose monitoring and medication management. R1's Service Plan, dated March 14, 2022,	0 950		

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0 950	Continued From page 26 included the assisted living contract terms. The contract lacked documentation indicating R1 was given the opportunity to designate a representative for certain purposes. On August 22, 2022, at 2:23 p.m., assisted living director (ALD)-C stated the contract included in the residents' Service Plan was the same as was used by the previous owners. ALD-C verified that was the contract they used for new admits. ALD-C further stated they provided all existing residents a new copy of that contract in response to the new Assisted Living Licensure. ALD-C indicated they have a new contract to use, but had not implemented it yet. On August 23, 2022, at 2:00 p.m., during the exit conference, ALD-C acknowledged the current contract was missing required elements, including the "Right to Designate a Representative" form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff	01440		

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01440	Continued From page 27 performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one unlicensed staff (unlicensed personnel (ULP)-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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired April 1, 2022, and provided direct care services for the residents of the facility.	01440		

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01440	Continued From page 28 On August 23, 2022, at approximately 9:00 a.m., ULP-B was observed to assist R1 with a blood glucose check, and then administer medications to R1. ULP-B's employee record indicated she received training on blood glucose testing on April 4, 2022, and medication administration on April 21, 2022. ULP-B's record lacked documentation the RN completed a 30-day supervision of ULP-B performing delegated tasks. On August 23, 2022, at 9:40 a.m., RN-A stated she was responsible for ULP training. RN-A stated ULP-C was trained on medication administration and blood glucose testing when hired. RN-A further stated she had not done a 30-day supervision to observe ULP-B for medication administration or blood glucose checks because she had not yet created the form to use. The licensee's Supervision of Unlicensed Personnel policy, undated, indicated, "Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our facility and has been trained and determined competent to perform all the tasks assigned." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 29 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 14-days after admission and every 90-days thereafter 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, but was not likely to cause serious injury, impairment, or death), and	01620		

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01620	Continued From page 30 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: R1 was admitted March 14, 2022, and received services including assistance with meals, housekeeping, laundry, transfers, ambulation, blood glucose monitoring and medication management. R1's record included a 14-day nursing reassessment completed March 23, 2022, and 90-day nursing assessments completed on May 15, 2022, and August 1, 2022. The nursing assessments were provided in progress notes. The nursing assessments did not follow a comprehensive standardized uniform assessment tool. R1's RN 14-day reassessment and 90-day assessments lacked several comprehensive assessment items identified in the facility nursing assessment policy. On August 23, 2022, at 2:23 p.m., registered nurse (RN)-A acknowledged 14-day reassessment and 90-day assessments required a comprehensive assessment. The licensee's Initial and On-Going Nursing Assessment of Residents policy and procedure, revised February 1, 2022, indicated, "A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules. Current and historical records and information are reviewed to the extent they are made available to the RN and if the RN is aware of these records. Comprehensive assessment will include:	01620		

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01620	Continued From page 31 a. The resident's personal lifestyle preferences, including: i. Sleep schedule, dietary and social needs, leisure activities, and other customary routines that are important to the resident's quality of life; ii. Spiritual and cultural preferences Advanced health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" b. Activities of daily living, including: i. Toileting pattern, bowel, and bladder control ii. Dressing, grooming, bathing, and personal hygiene iii. Mobility, including ambulation, transfers, and assistive devices iv. Eating, dental status, oral care, and assistive devices and dentures if applicable. c. Instrumental activities of daily living, including: i. Ability to self-manage medications ii. Housework and laundry iii. Transportation d. Physical health status, including: i. Review of relevant health history and current health conditions including: 1. Medical diagnosis 2. Nursing diagnosis to the extent they are available to the RN ii. Medication allergies and sensitivities iii. Seasonal, environmental, food and life threatening allergies or sensitivities iv. Infectious conditions v. Medication review including OTC medications, prescription medications and supplements including: 1. Reason taken 2. Side effects, contraindications, allergic or adverse reactions 3. Actions to address side effects,	01620		

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01620	Continued From page 32 contraindications, allergic or adverse reactions 4. Dosage 5. Frequency of use 6. Route administered 7. Resident difficulties taking medications 8. Self-administration vs. other type of administration 9. Resident preferences for taking medications 10. Medication management interventions to prevent drug diversion by the resident or others who have access to medications 11. Instructions to the resident and resident's legal/designated representatives on interventions to manage the resident's medications and prevent medication diversion vi. Use and effect of medications including any psychotropic meds vii. Review medical, dental, and emergency room visits in the past 12 months to the extent they are available to the RN viii. Review primary care provider visits, hospitalizations, surgeries, and care from post-acute care facilities in the past 12 months to the extent they are available to the RN ix. Review of physical therapist, occupational therapist, speech therapist or cognitive evaluations with the last 12 months to the extent they are available to the RN to the extent they are available to the RN x. Weight xi. [vital signs] if indicated by health conditions or medications e. Emotional and mental health conditions including: i. History and current diagnosis of mood disorders including depression, anxiety, bipolar disorder, and thought or behavioral disorders to the extent they are available to the RN	01620		

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01620	Continued From page 33 ii. Current symptoms of mental health conditions and behavioral expressions of concerns iii. Effective medication, treatment, and nonmedication interventions f. Cognition, including: i. Review of any neurocognitive evaluations and diagnosis ii. Current memory, orientation, confusion, and decision-making ability g. Communication and sensory capabilities including i. Hearing ii. Vision iii. Speech iv. Assistive communication and sensory devices including hearing aids v. Ability to understand and be understood h. Pain i. Location ii. Frequency iii. Intensity iv. Duration v. Effectiveness of medication and nonmedication alternatives for pain i. Skin conditions j. Nutritional and hydration status and preferences k. List of treatments including i. Type ii. Frequency iii. Level of assistance needed l. Nursing needs, including potential to receive nursing-delegated services m. Risk indicators i. Risk of falls ii. Fall history iii. Emergency evacuation ability iv. Complex medication regimen v. Risk for dehydration vi. History of urinary tract infections	01620		

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01620	Continued From page 34 vii. Current fluid intake pattern viii. Risk for emotional or psychological distress due to personal losses ix. Unsuccessful prior placements to the extent the information is available to the RN x. Elopement risk xi. History of / previous elopements to the extent they are available to the RN xii. Smoking including the ability to smoke without causing burns or injury to the resident or others or damage to property xiii. Alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician to the extent the information is made available to the RN n. Decision making authority for the resident i. Presence of any advanced health care directive or other legal document that establishes a substitute decision making ii. Scope of the decision-making authority of a substitute decision making iii. The need for follow-up referrals for additional medical or cognitive care by health professionals o. An assessment of the resident's areas of vulnerability and susceptibility to maltreatment and whether the resident poses a risk to other vulnerable adults." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650		

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01650	Continued From page 35 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all 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	01650		

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01650	Continued From page 36 of the residents). The findings include: R1 was admitted March 14, 2022. R1's service plan, signed March 15, 2022, indicated R1 received services including setup dressing and grooming, COVID monitoring, medication management, cognitive behavioral support, additional shower, transfer assistance, blood glucose (BG) monitoring, incontinence, overnight assistance (average 1 time per night), ambulation assistance, and laundry. R1's Service Plan, signed March 15, 2022, lacked the following required items: - the category of staff who would provide the services; - the schedule and method of monitoring assessments of the resident; - the schedule and method of monitoring staff providing services; On August 23, 2022, at 2:24 p.m., assisted living director (ALD)-C acknowledged the missing information from the service plan. ALD-C stated all residents were given the same contract and service plan form with the new assisted living licensure. The Licensee's Contents of Service Plan policy and procedure, revised on February 1, 2022, indicated service plans would include: -A description of the services provided; -Fees for services; -Frequency of each service according to resident assessment and resident preferences; -Schedule and methods of monitoring assessments;	01650		

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01650	Continued From page 37 -Schedule and methods of monitoring staff providing services; -A contingency plan that includes; i. Action taken if the scheduled service cannot be provided; ii. Information and method to contact the facility; iii. Names and contact information of persons the resident wishes to have notified in an emergency; iv. Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition; v. Identification of and information on who has authority to sign for the resident in an emergency; vi. Circumstances in which emergency medical services are not to be summoned; -The service plan and revisions will be entered into the resident record; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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	01730		

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01730	Continued From page 38 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; (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 observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1).	01730		

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01730	Continued From page 39 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: R1 was admitted March 14, 2022, with a diagnosis of chronic obstructive pulmonary disease (COPD). R1's service plan, signed March 15, 2022, indicated R1 received services including assistance with medication management. On August 23, 2022, at 2:17 p.m., at 9:00 a.m., unlicensed personnel (ULP)-B was observed administering medications to R1. R1's medication management plan, dated March 14, 2022, lacked the following: - description of storage of medications based on the resident's needs and preferences and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - the medication management record must be current and updated when there are any changes; - medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management; R1's August 2022, medication administration record (MAR) indicated he was taking the	01730		

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	30796	A. BUILDING: _____ B. WING _____	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRASK HAVEN INC	31274 JULLIARD ST NE NORTH BRANCH, MN 55056

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01730	Continued From page 40 following medication which were not included in R1's March 14, 2022 medication management plan: - acetaminophen - 500 mg PRN for pain. Give 2 tablets by mouth PRN for pain - or every 6 hours; - nitroglycerin - Give 0.4 milligrams (mg) under the tongue PRN for chest pain, give every 5 minutes if needed; - Entresto (for heart failure) - Give 97 - 103 mg 1 tablet by mouth twice daily; - tamsulosin (for urinary health) HCL - Give 0.4 mg capsule by mouth daily; R1's medication medication management plan dated March 14, 2022, was not up to date with the medications found on R1's August 2022, MAR: - insulin glargine(a long-acting insulin) - medication management plan indicated to take 22 units subcutaneously (under the skin) every day at bedtime versus 20 units every day as indicated on the MAR; - levothyroxine (a thyroid medication) - medication management plan indicated to take 200 micrograms (mcg) every morning by mouth versus 175 mg as indicated on the MAR; The licensee's Documentation of Medication, Treatment and Therapy Management Services policy and procedure, revised on February 1, 2022, indicated, "The RN will document the services the resident will receive on the resident's individualized medication management plan and individualized treatment and therapy plan and resident's medication/treatment record or MAR/TAR." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01730		

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01730	Continued From page 41 days	01730		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to administer medication per provider orders for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01760		

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01760	Continued From page 42 R1 was admitted March 14, 2022. R1's service plan, signed March 15, 2022, indicated R1 received services including assistance with medication management. On August 23, 2022, at 9:00 a.m. unlicensed personnel (ULP)-B was observed to assist R1 with medication administration. R1's medication administration record (MAR) indicated: - insulin aspart (Novolog) flexpen (a fast-acting insulin) - inject 8 units of insulin aspart (Novolog) subcutaneously before meals. HOLD IF BLOOD GLUCOSE LEVEL IS < 150. Monitor for hyper/hypo glycemia (high or low BG) symptoms which include confusion, heart palpitations, shakiness, anxiety, elevated BG, increased thirst, blurred vision, frequent urination, headache. On August 23, 2022, at 9:00 a.m., after R1 had eaten breakfast, ULP-B checked R1's blood glucose (BG) to determine if insulin would need to be administered. ULP-B stated R1's BG was 168. ULP-B further stated she would need to give R1 insulin because his BG was over 150. On August 23, 2022, at 9:04 a.m., the surveyor asked if there was a protocol for insulin administration if R1's blood glucose was checked after eating. ULP-B stated there was no direction for insulin administration if R1 had already eaten before his BG could be checked. On August 23, 2022, at 9:05 a.m., ULP-B was observed to prepare R1's insulin. ULP-B wiped R1's right tricep area with an alcohol wipe to administer insulin. The surveyor stopped ULP-B from administering R1's insulin.	01760		

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01760	Continued From page 43 -at 9:08 a.m., ULP-D asked ULP-B why she was going to give R1 insulin. ULP-D stated she had already checked R1's BG before R1 began eating his breakfast, and R1's BG was 102 at that time. ULP-D further stated she did not have time to document R1's BG. ULP-B stated she would not administer R1's insulin based on the information provided by ULP-D. On August 23, 2022, at 9:20 a.m., registered nurse (RN)-A acknowledged R1's insulin should not have been administered when R1's BG was checked after eating. RN-A further stated ULP-B should have notified the nurse. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy and procedure, revised February 1, 2022, indicated: Medications, treatment, and therapy always need to be administered according to the "6 Rights" a. Right person b. Right medication, treatment, or therapy c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc.) f. Right chart/record to document that the medication, treatment, and therapy was taken No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

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01880	Continued From page 44 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure medications were stored under proper temperature controls according to manufacturer instructions. This had the potential to affect two of two (2) residents (R1, R3) with refrigerated medications. Further, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and only authorized personnel had access. This had the potential to affect all residents in 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) 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: On August 22, 2022, at 11:57 a.m., the medication refrigerator, on the main floor in the dining area, was observed to contain insulin medications for R1. The refrigerator was unlocked. Further, the medication refrigerator had no thermometer and there was no log of temperature monitoring for the refrigerator. The main floor medication refrigerator contained the following medications labeled for R1: -1 pen Lantus Solostar (a long-acting insulin) in top tray	01880		

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01880	Continued From page 45 -4 more Lantus Solostar in bottom (1 pen marked with the date opened "8/15/22"). -4 pens Novolog flexpen (a fast-acting insulin) -1 pen Basaglar (a long-acting insulin) marked as opened 3/8/22. A label on the pen stated "refrigerate". The pen was in a plastic bag with a note indicating not to use the pen. On August 23, 2022, at 10:35 a.m. the medication refrigerator, located on the lower level, in a hallway, was observed to contain insulin medications for R3. The refrigerator was unlocked. Further, the medication refrigerator had no thermometer and there was no log of temperature monitoring for the refrigerator. The lower level medication refrigerator contained food including drumsticks, bottle of soda, and a bottle of water in the freezer. The refrigerator contained a bottle of salad dressing and steak sauce in the door, a plastic bag with leftover food inside, and 3 plastic containers of food. The refrigerator further contained a locked storage box (unable to be opened) and the following medications: R3: -1 unopened box (4 pens) of Trulicity (a diabetes medication). -3 unopened pens, 1 open pen Basaglar kwikpen R2 (discharged resident): 1 bottle latanoprost (for glaucoma) eye drops Manufacturer storage instructions observed on the packaging for Lantus Solostar indicated,"unopened Lantus Solostar devices should be stored in a refrigerator 36-46 deg [degrees] F [Fahrenheit] (2-8 deg C [Celsius]) Do not freeze." Manufacturer storage instructions observed on the packaging for Novolog flexpen indicated, "Store Refrigerated at 2 deg C to 8 deg C (36 F to	01880		

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01880	Continued From page 46 46 deg F) until first use. After first use, store at room temperature (up to 30 deg C [86 deg F]) Avoid freezing". Manufacturer storage instructions for Basaglar kwikpen, revised July 2021, indicated opened and unopened Basaglar kwikpen may be stored at room temperature (up to 86 degrees F) up to 28 days, opened Basaglar kwikpen should not be refrigerated, and unopened Basaglar kwikpen may be stored refrigerated until the expiration date. Manufacturer storage instructions observed on the packaging for Trulicity, indicated, "refrigerate 36-46 degrees (2 deg c-8 deg c) up to expiration date. On August 22, 2022, at 12:15 p.m., ULP-B stated she did not perform temperature checks of the the main floor medication refrigerator, and staff did not document temperatures. On August 23, 2022, at 10:54 a.m., assisted living director (ALD)-C stated he knew food should not be stored in the refridgerator with medications. ALD-C indicated the locked box in the lower level refrigerator contained unused narcotics from a new hospice admit. ALD-C acknowledged they needed to keep both refrigerators locked. ALD-C further stated he had already ordered thermometers for both medication refrigerators, and would instruct staff to document daily temperatures. The licensee's Storage of Medications policy, revised February 1, 2022, indicated, "Medications will be handled and stored per acceptable standards."	01880		

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01880	Continued From page 47 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained including the opened date for time sensitive medication storage 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 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: R1 was admitted on March 14, 2022. R1's service plan, signed March 15, 2022, indicated R1 received services including assistance with showering, dressing and	01890		

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01890	Continued From page 48	01890		

grooming, medication management, cognitive behavioral support, transfers, ambulation, blood glucose (BG) monitoring, incontinence, housekeeping and laundry.

On August 23, 2022, at 9:00 a.m. unlicensed personnel (ULP)-B was observed to assist R1 with medication administration.

Insulin Administration
R1's medication administration record (MAR) indicated:
- insulin aspart (Novolog FlexPen) - inject 8 units of insulin aspart (Novolog FlexPen) subcutaneously before meals. HOLD IF BLOOD GLUCOSE LEVEL IS < 150. Monitor for hyper/hypo glycemia (high or low BG) symptoms which include confusion, heart palpitations, shakiness, anxiety, elevated BG, increased thirst, blurred vision, frequent urination, headache.

Manufacturer instructions indicated Novolog FlexPen should be discarded 28 days after being opened.

On August 23, 2022, at 9:05 a.m., while ULP-B was preparing R1's insulin, the surveyor requested to see the opened date on the pen. ULP-B stated R1's Novolog FlexPen had not been labeled with an opened date. ULP-B stated she was not the one who opened it and was unsure how long it had been opened.
-at 9:08 a.m., ULP-B was observed to wipe R1's right triceps area with an alcohol wipe to administer insulin. ULP-B was stopped from administering the medication.

On August 23, 2022, at 9:20 a.m., registered nurse (RN)-A acknowledged R1's Novolog insulin pen should have been marked with an opened

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01890	Continued From page 49 date and should not have been used. The licensee's Storage of Medications policy and procedure, revised February 1, 2022, indicated, "Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01940		

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01940	Continued From page 50 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 ensure the registered nurse (RN) developed and implemented a treatment or therapy management plan to include all 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 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: R1 was admitted March 14, 2022. R1's service plan, signed March 15, 2022, indicated R1 received services including assistance with blood glucose monitoring three	01940		

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01940	Continued From page 51 times daily. R1's treatment administration record (TAR) for August 2022, indicated R1 received assistance with blood glucose monitoring three times daily from August 1-22, 2022. R1's record lacked a treatment or therapy management plan to include the following: -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; 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 August 23, 2022, at 11:45 a.m. assisted living director (ALD)-C acknowledged the treatment management plan needed further development to include identifying tasks delagated to unlicensed personnel as well as individualization to the resident. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy, revised February 1, 2022, indicated, "The RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the unlicensed personnel have satisfied the training requirements listed above if: a. Before performing the procedures, the RN has instructed the unlicensed personnel in the proper methods to administer the medications, treatment	01940		

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01940	Continued From page 52 and therapy and the unlicensed personnel have demonstrated the ability to competently follow the procedures; b. The RN has developed written, specific instruction for each resident c. The RN has communicated with the unlicensed personnel about the individual needs of the resident; and d. The RN has documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a prescriber order for blood glucose (BG) monitoring, including the frequency, duration and other information needed to administer the treatment for one of one resident (R1).	01970		

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01970	Continued From page 53	01970		

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:

R1 was admitted March 14, 2022.

R1's service plan, signed March 14, 2022, indicated R1 received services including assistance with blood glucose monitoring three times daily.

R1's treatment administration record (TAR) for August 2022, indicated R1 received assistance with blood glucose monitoring three times daily from August 1-22, 2022.

On August 23, 2022, at 9:00 a.m., unlicensed personnel (ULP)-B was observed to assist R1 with blood glucose monitoring.

On August 23, 2022, at 10:44 a.m., registered nurse (RN)-A stated there were not orders to check BG for R1, however within R1's insulin orders it indicated they should hold insulin if the BG was below 150 which indicated the BG should be checked. The surveyors explained there needed to be a separate treatment order for BG monitoring. RN-A acknowledged the requirement.

The licensee's Medication, Treatment and Therapy Reminders policy, revised February 1, 2022, indicated, "Residents will receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30796	A. BUILDING: _____ B. WING _____	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRASK HAVEN INC	31274 JULLIARD ST NE NORTH BRANCH, MN 55056

(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
01970	Continued From page 54 medication, treatment, and reminders per RN assessment and provider orders." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01970		

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

Type: Full
Date: *08/22/22*
Time: 12:30:00
Report: 1025221166

Food and Beverage Establishment Inspection Report

Location:
Brask Haven Inc
31274 Julliard St Ne
North Branch, MN55056
Isanti County, 30

Establishment Info:
ID #: 0039050
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516747433
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.

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

Chlorine solution in dish machine at 0 PPM. Discontinue use of the machine for sanitizing; adjust/repair and test prior to using to sanitize utensils.

Comply By: 08/22/22

3-500A Microbial Control: cooling

3-501.15A ** Priority 2 **

MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

Hot dish from lunch cooling in a sealed plastic container. Cool hot foods uncovered and in metal or glass to conduct heat away. Food transferred to a metal bowl and placed in cooler to complete cooling.

Corrected on Site

4-200 Equipment Design and Construction

4-204.117B ** Priority 2 **

MN Rule 4626.0643B Provide a visual or audible signal on the warewashing machine to alert user when detergent and sanitizer are not being delivered during the respective cycles.

Dish machine did not have a visual or audible alert, alarm, or signal. Provide equipment with a compliant system.

Comply By: 08/22/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

For more details, search "MDH CFPM"
https://www.health.state.mn.us/communities/environment/food/cfpm/index.html

Comply By: 08/22/22

Surface and Equipment Sanitizers

Chlorine: = 0 PPM at Degrees Fahrenheit
Location: Dish machine
Violation Issued: Yes

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: Spray bottle
Violation Issued: No

Quaternary Ammonia: = 300 PPM at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Upstairs refrigerator
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Downstairs refrigerator
Violation Issued: No

Process/Item: Mini cooler
Temperature: Degrees Fahrenheit - Location: Resident personal items only
Violation Issued: No

Process/Item: Hallway refrigerator
Temperature: Degrees Fahrenheit - Location: Resident personal items only
Violation Issued: No

Process/Item: Juice (non TCS)
Temperature: 41 Degrees Fahrenheit - Location: Downstairs upright cooler, top
Violation Issued: No

Process/Item: Beef, pkg
Temperature: Degrees Fahrenheit - Location: Downstairs upright cooler, bottom
Violation Issued: No

Process/Item: Hot dish
Temperature: 100 Degrees Fahrenheit - Location: Cooling reported < 30 min
Violation Issued: No

Process/Item: Chicken BBQ
Temperature: 40 Degrees Fahrenheit - Location: Downstairs upright cooler
Violation Issued: No

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

Discussed
Food source (Wal-Mart, delivery used; discussed verification of delivery and refusal of damaged, adulterated, or unsafe items; recalls)
Cooking temperatures and TMD use (bi metal vs digital/thin probe)
Cooling process (cool TCS foods in metal, plastic, uncovered; can be stored in plastic, covered, once cool)

Upstairs dishwasher has an ETL sanitation residential bug, reported not used or operating due to water leak.

Upstairs sink – designate one basin for handwashing and handwashing only.

Downstairs has a kitchen which meets requirements of MN 4626.0506 for TCS foods serviced for multiple day service. This means that TCS foods can be cooked and cooked, but can only be done so in this kitchen space in the upright stainless cooler. The refrigerators in the facility used to store non-resident items (food the facility is providing) should be used instead for non-TCS items. The exemption for equipment not meeting the requirements of MN 4626.0506 is only for facilities which do not cool, save, or serve TCS for multiple-day service. (So, the facility can cool and save leftovers, but then also cannot use the noncompliant/residential equipment. The facility could use the residential equipment, but only if it discontinued serving/saving TCS foods for more than same-day service).

The freezer on the covered deck is used for personal items for 1 resident only. This equipment should be operated in a conditioned space (e.g. basement, somewhere where air temperatures do not exceed the manufacturer's requirements). The facility cannot store its own items which will be provided to residents in this freezer, unless it is in a conditioned space.

The basement dish machine was not fully functional during the inspection, as it was not dispensing sanitizer during cycles, only when primed. The 3 compartment sink was set-up using quaternary ammonia tablets to 400 PPM and staff were instructed how to use the method, prepare the sanitizer, and how to instruct the next shift on how to sanitize utensils. There were bleach/chlorine test kits on-site, and quat ammonia tabs, but no non-laundry bleach (only bleach without label directions for "food contact surfaces"), and no quat ammonia kit was available. Provide a test kit for all sanitizer types used in establishment. Use all chemicals per their label directions.

Replacement of the dish machine was discussed. A low temp unit is existing, but the facility is on septic, so be advised if there are issue with the septic system, alert any service or contractor there is a chlorine dish machine on-site, as this could potentially affect the bacterial composition of the tank. A high temp unit could be used, but it would need to be ventless/would need a built-in condenser. Be advised that even ventless units still produce a fair amount of heat and steam, and the use of the unit must follow local building requirements.

The 3 compartment sink alone with an adequate sanitizing solution can also be used in lieu of any mechanical dish machine. The dish machine is not required.

Discussed providing an appropriate food contact surface (e.g. plastic cutting boards) for the upstairs

kitchen for resident use if they'd like to prepare their own meals, to avoid using/damaging the wood counter. (Facility food prep occurs in the basement on stainless surfaces).

Foodservice for Highly Susceptible Populations:
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

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 1025221166 of 08/22/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025221166

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	2	Date 08/22/22
No. of Repeat RF/PHI Categories Out	0	Time In 12:30:00
Legal Authority MN Rules Chapter 4626		Time Out

Brask Haven Inc	Address: 31274 Julliard St Ne	City/State: North Branch, MN	Zip Code: 55056	Telephone: 6516747433
License/Permit #: 0039050	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	X	Proper cooling methods used; adequate equipment for temperature control	X	
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	X	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:** 08/23/22

Inspector (Signature) Cory Kline