Electronically Delivered

July 7, 2023

Licensee
TFF Care LLC
4200 40th Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL21574015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 7, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

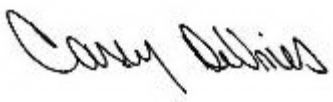
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21574	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	4200 40TH AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21574015-0 On June 5, 2023, through June 7, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 160 active residents: 72 of whom received services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 6, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be	0 630		

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0 630	Continued From page 2 taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of seven residents (R6). 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: R6 admitted to licensee December 30, 2022. R6 was a housing only resident and did not receive services from the licensee. R6's undated IAPP indicated R6 had no vulnerability. R6's IAPP lacked the following content: - assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; - the person's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse. On June 7, 2023, at 11:45 a.m., clinical nurse	0 630		

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0 630	Continued From page 3 supervisor (CNS)-A stated the vulnerability assessment lacked identified content above and stated the software licensee used did not give them the options for the content above. CNS-A also stated all housing only residents' IAPP would be missing the required content above. The licensee's Vulnerable Adult Reporting and Investigation policy indicated in accordance with state and federal vulnerable adult laws, our agency's employees will report any suspected maltreatment (abuse, neglect or financial exploitation as defined in MN Statutes §626.5572) of our residents. Staff will be trained on the Vulnerable Adult Act and our reporting policy. The licensee's policy lacked the required content for an abuse prevention plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 4 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content (annual performance review) for two of two employees, (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: LPN-C started employment with licensee on August 3, 2010, under the former comprehensive license, and started providing assisted living services August 1, 2021. LPN-C's employee record included a Supervisor's Employee Performance Appraisal form dated August 24, 2017, but lacked evidence of further annual performance reviews.	0 650		

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0 650	Continued From page 5 ULP-D started employment with licensee March 7, 2012, under the former comprehensive license, and started providing assisted living services August 1, 2021. ULP-D's employee record lacked evidence annual performance reviews were completed. On June 7, 2023, at 10:43 a.m., clinical nurse supervisor (CNS)-A stated they were not surprised annual reviews for LPN-C and ULP-D were missing, and stated licensee needed to improve in this area. On June 7, 2023, at 3:14 p.m., CNS-A indicated via email ULP-D's record lacked annual performance reviews for the years 2021, 2022, and 2023. The licensee's Documentation of Observation of licensed and Unlicensed Personnel policy dated August 1, 2021, indicated both licensed and unlicensed staff will be supervised by designated supervisors to ensure that the staff is performing their job duties competently, consistently with any professional standards that may apply and consistently with company policy and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 6 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a completed health history and symptom screening, a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for two of two employees (licensed practical nurse (LPN)-C, and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by Minnesota Department Health (MDH) dated May 1, 2023, indicated licensee's TB risk level was	0 660		

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0 660	Continued From page 7 low. LPN-C LPN-C started employment with licensee on August 3, 2010, under the former comprehensive license, and started providing assisted living services August 1, 2021. LPN-C's employee record lacked documentation of the following: - TB history and symptom screening; and - a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. ULP-D ULP-D started employment with licensee March 7, 2012, under the former comprehensive license, and started providing assisted living services August 1, 2021. ULP-D's employee record included a chest x-ray completed on January 17, 2013. ULP-D's record lacked the following: - TB history and symptom screen; and - a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. On June 7, 2023, at approximately 9:45 p.m., clinical nurse supervisor (CNS)-A stated all new employees should receive a two-step Mantoux upon hire. On June 7, 2023, at 3:14 p.m., CNS-A indicated via email "I am not locating this in the chart from hire year of 2012", referring to TB screening- 2 step Mantoux. The Minnesota Department of Health's web page under the Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota to	0 660		

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0 660	Continued From page 8 include: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The licensee's TB Prevention and Control policy dated, August 1, 2021, indicated licensee will establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The Minnesota Department of Health guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings will be followed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal	0 730		

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0 730	Continued From page 9 representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	0 730		

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0 730	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document services were provided as identified in the service plan for two of five residents (R1, R2). 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 R1's service plan dated June 20, 2019, indicated R1 received services for morning cares, dining reminders, laundry, medication administration, and reassurance checks. R1's May Service Recap Summary lacked documentation for the following services: -reassurance checks, 11 missing documentations; -AM (morning) cares, one missing documentation; -dining reminders, one missing documentation; - make bed, one missing documentation; -medication management setup, four missing documentations; -monitoring continence, one missed documentation; -forgetful behavior, seven missed documentations; and	0 730		

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0 730	Continued From page 11 -trash removal, three missed documentations. R2 R2's service plan dated November 1, 2022, indicated R2 received services for housekeeping and reassurance checks. R2's May Service Recap Summary lacked documentation for the following services: -housekeeping, it was on the service plan but was not in the Service Recap Summary. On June, 7, 2023, at 10:40 a.m., clinical nurse supervisor (CNS)-A stated their expectation was for something to always be documented, staff should be documenting why a service was not provided but should never be left blank. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
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 physical environment,	0 800		

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0 800	Continued From page 12	0 800		

including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

Findings include:

On a facility tour on June 08, 2023, from approximately 9:30 a.m. to 1:00 p.m. with the Director of Maintenance (DM)-F it was observed that the "Tavern" on the fifth floor had light fixtures that were starting to fall from the ceiling. One of the large light fixtures was secured by only two points.

The ceiling vents outside the tavern were covered in cobwebs, dust, and lint. The walls and ceiling in that area were also covered with dust and cobwebs. The Tavern was located on the atrium walkway which was very narrow and had tall ceilings. DM-F stated that the ceilings were 16'-0" above the walkway and very difficult to clean due to the narrow walkway having very little space to erect scaffolding and nowhere to tie off to prevent falls. The safe conditions were noted around the entire atrium space.

It was observed that the east wing patio door by

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	4200 40TH AVENUE NORTH ROBBINSDALE, MN 55422

(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
0 800	Continued From page 13 the men's restroom had water damage. The sealant was degraded and the gaskets on the door had either been removed or never installed. The paint had signs of staining and puckering around the door frame and the frame was loose in the wall. DM-F stated that water penetration had been an ongoing issue at both patio locations. He stated they had recently addressed the water issues at both patios, but hadn't finished the interior work to fix the remaining damage. The third-floor laundry room floor under the driers had a significant dip in the floor structure. The area felt soft and squishy when stepped on. DM-F stated he did not know why the floor was sagging so significantly. The second-floor laundry room, located directly under the third-floor laundry room, showed signs of ceiling damage caused by water. The ceiling was dry to the touch on the day of the survey but had significant staining in the same location as the damaged floor above. The fourth washing machine in the second-floor laundry room had a significant amount of damage to the wall and base behind it. Dark staining and corrosion were observed around the plumbing elements. DM-F visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 14 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements and	0 810		

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0 810	Continued From page 15 failed to provide required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on June 08, 2023, at approximately 1:30 p.m. with the Director of Maintenance (DM)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Review of the posted evacuation diagrams showed they did not show the location and number of resident rooms. DM-F verified that the diagrams lacked the location and number of resident rooms. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and	0 810		

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0 810	Continued From page 16 unusual needs of the residents. During interview, DM-F verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, DM-F stated the licensee did not have any documentation on completing employee training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, DM-F stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with	0 820		

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0 820	Continued From page 17 a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide separated, and secured areas for parts of the building that were under construction and failed to conduct a fire watch while the life safety system was offline in the areas under construction. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On a facility tour on June 08, 2023, from approximately 9:30 a.m. to 1:00 p.m. with the Director of Maintenance (DM)-F it was observed that the third-floor and second-floor east wings were under construction. DM-F stated they had a small fire in the east wing earlier in the year and the sprinklers had gone off and done significant damage to the hallway and apartments on the third floor and the second floor below it. It was observed that the construction area on the	0 820		

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0 820	Continued From page 18 third floor was open to the rest of the building and anyone could access the area without any restriction. The apartments were unlocked and used by the construction company to store materials and tools while workers were not on site. It was observed that the construction area on the second floor was open to the rest of the building and anyone could access the area without any restrictions. The apartments were unlocked and used by the construction company to store materials and tools while workers were not on site. The ceiling tiles had been removed from the hallway exposing all the plumbing, ductwork, and wiring. Without the ceiling tiles, the sprinkler system would not function as it was designed to function. Smoke and heat from a potential fire would gather at the higher ceiling in the plenum space, bypassing the sprinkler head and potentially not activating the sprinkler system. Without the ceiling tiles, smoke could also penetrate the duct system and be distributed to the rest of the building before the sprinkler system is activated. The kitchen pantry and staff breakroom were directly adjacent to the construction area and no measures were in place for construction dust control, infection control, or any other safety measure for an active construction zone. Survey staff observed kitchen staff entering and exiting the construction zone carrying fresh bananas and other food items that were going to be served to residents at mealtime. Residents were seated in the atrium dining area for their mid-day meal less than thirty feet from the construction area. It was observed that apartments 219 and 222 were occupied by independent living residents	0 820		

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0 820	Continued From page 19 while construction was happening both inside and directly outside their apartments. Residents would have to walk through the active construction area to leave the building, attend social events in other parts of the building, or get their mail. Survey staff asked DM-F if the facility was taking any measures to control the potential spread of construction dust, if the facility was taking any measures to control the possible spread of infectious material possibly released into the air by the removal of wet building materials like carpeting, drywall, and ceilings, and if the facility had implemented any procedures for a fire watch in the construction areas since the sprinkler system would not function as it was designed when the ceiling tiles are missing. DM-F stated that they had not taken any measures to secure the construction areas, control the possible spread of dust or other airborne irritants, or ensure the construction area was being monitored for fire risk while the ceiling tiles were removed. Current guidelines from the Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities recommends implementing infection-control measures relevant to construction, renovation, maintenance, demolition, and repair. The CDC recommends construction barriers be installed to prevent dust from construction areas from entering resident-care areas. The CDC also recommends relocating patients whose rooms are adjacent to work zones, depending on their immune status, the scope of the project, and the potential for the generation of dust or water aerosols. These recommendations and additional CDC	0 820		

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0 820	Continued From page 20 recommendations can be found in the CDC MMWR's "Guidelines for Environmental Infection Control in Health-Care Facilities" Report issued on June 6th, 2003 DM-F visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
0 950 SS=C	144G.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 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	0 950		

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0 950	Continued From page 21 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 include verbatim language giving residents the right to identify a designated representative for five of five residents (R1, R2, R3, R4, R5). 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 the potential to affect a large portion or all the residents). The findings include: On June 5, 2023, the licensee provided a blank copy of their Resident Agreement. Attachment A, page 25, of the contract was for designation of a representative but did not include the following required verbatim language: "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 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of	0 950		

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0 950	Continued From page 22 attorney ("health care agent"), if applicable." R1, R2, R3, R4 and R5's signed Resident Agreements were reviewed and lacked the required verbatim language giving the right to identify a designated representative in Attachment A, page 25. The contracts included the following language: "You may name a Designated Representative and other contacts below. Those named as Legal Representative or Designated Representative may be referred to as ("resident representative" or "representative") throughout this Agreement. You may change them at any time by notifying Provider in writing. If you name more than one person, please note Provider will only contact the one person necessary depending on the situation. Not every person listed will be contacted individually. For example, if two persons are named as emergency contacts, only one will be notified in an emergency." On June 7, 2023, at 10:40 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A both acknowledged the language was incorrect and would correct it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or	0 970		

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0 970	Continued From page 23 should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living with dementia care facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 5, 2023, at approximately 11:10 a.m., clinical nurse supervisor (CNS)-A provided the surveyor a blank Resident Agreement and indicated the resident agreement was used by the licensee for all residents. The blank resident agreement included the following two sections which included language waving the facilities liability for health, safety, or personal property of a resident: Page 21: 27. LIABILITY "Provider is not responsible for any loss, damage or injury that is done to Resident's property	0 970		

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0 970	Continued From page 24 (including personal effects and medical equipment such as walkers, canes, dentures and hearing aids) in the Apartment or Community caused by fire, water, explosion or any other cause other than by proven willful misconduct by Provider's employees." "Provider is not responsible for any damage or injury that is done to Resident or Resident's guests in the Apartment or Community caused by fire, water, explosion or any other cause other than by proven willful misconduct or proven failure to provide the required standard of care by Provider's employees." On June 7, 2023, at 10:45 a.m., licensed assisted living director (LALD)-B stated licensee was aware of the waiver in the contract from another survey in a location owned by licensee. LALD-B also stated licensee intended to request reconsideration for the waiver correction order. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01440 SS=D	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	01440		

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01440	Continued From page 25 to perform the tasks. Supervision of staff 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 observation and record review, the licensee failed to ensure the registered nurse (RN) provided direct supervision of staff performing delegated tasks within 30 calendar days after tasks were delegated for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D started employment with licensee March 7, 2012, under the former comprehensive license, and started providing assisted living services August 1, 2021.	01440		

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01440	Continued From page 26 On June 6, 2023, between 6:30 a.m., and 10:20 a.m., the surveyor observed ULP-D administer medications to residents residing in the secured unit. On June 8, 2023, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated it was possible employees who had worked for licensee for a long time may not have 30-day supervisions in record, as licensee had changed ways of documenting and tracking employee records many times to the current system. On June 8, 2023, at 2:36 p.m., CNS-A, sent via email a Skills Competence Checklist dated March 8, 2012, one day after ULP-D's start of employment and indicated "what I have found from March 2012 in way of supervision/education". ULP-D's employee record lacked documentation of supervision within 30 calendar days after the date medication administration tasks were delegated, and thereafter as needed based on performance. The licensee's Documentation of Observation & Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, indicated both licensed and unlicensed staff will be supervised by designated supervisors to ensure that the staff is performing their job duties competently, consistently with any professional standards that may apply and consistently with company policy and procedures. This supervision will be documented appropriately to ensure compliance can be demonstrated and to ensure a proper record is kept for each staff supervised.	01440		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	4200 40TH AVENUE NORTH ROBBINSDALE, MN 55422

(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
01440	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning	01500		

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01500	Continued From page 28 and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01500		

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01500	Continued From page 29 The findings include: ULP-D started employment with licensee March 7, 2012, under the former comprehensive license, and started providing assisted living services August 1, 2021. On June 7, 2023, at 3:15 p.m., clinical nurse supervisor (CNS)-A provided ULP-D's My Transcript with the following courses completed between September 22, 2022, and April 11, 2023: - reporting of maltreatment of vulnerable adults for 0.75 hours; - the assisted living bill of rights for 0.75 hours; - infection control techniques for 2.25 hours; - person-centered planning/service delivery for 0.5 hours. ULP-D's employee record had a total of 4.25 hours of annual training out of the required at least eight hours of annual training for each 12 months of employment. In addition, ULP-D's record of training lacked the following topic: - review of the facility's policies and procedure. On June 7, 2023, at 3:45 p.m., CNS-A stated she had provided all training record for ULP-D. CNS-A also stated licensee did not have any further training in record for ULP-D, however in the system it indicated ULP-D had been assigned the required training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01610	Continued From page 30	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment prior to signing the assisted living contract/providing services for one of five residents (R5). 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 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).	01610		

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01610	Continued From page 31 The findings include: R5 was admitted to the licensee on November 1, 2022. R5's Service Plan dated November 1, 2022, indicated R5 received services for housekeeping and reassurance checks. R5's record indicated the clinical nurse supervisor (CNS)-A had not completed an initial assessment until November 2, 2022, which indicated one day had passed since start of services. On June 7, 2022, at 10:40 a.m., CNS-A stated they were aware of the requirement, and it was a day late in completion. The licensee's Initial and On-Going Nursing Assessment of Clients policy dated August 1, 2021, indicated, "Pre-Admission Assessment - to be done prior to the initiation of nursing or delegated nursing or therapy or assigned therapy services or at least within five days of the initiation of home care services." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 32 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 reassessment and monitoring no more than 14 calendar days after initiation of services for four of five residents (R1, R2, R4, R5). 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:	01620		

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01620	Continued From page 33 R1 R1 was admitted to the licensee on June 20, 2019, for assisted living with dementia care services. R1's diagnosis included Alzheimer's disease. R1's Service Plan dated June 20, 2019, indicated R1 received services for morning cares, dining reminders, laundry, medication administration, and reassurance checks. R1's record included an initial admission assessment completed on June 20, 2019, and a 14-day assessment completed on July 18, 2019, which was past due by 14 days. R2 R2 was admitted to the licensee on November 10, 2022, for assisted living with dementia care services. R2's diagnosis included dementia, diabetes type 2, ischemic stroke and nontraumatic subcortical hemorrhage of left cerebral hemisphere. R2's service plan dated February 16, 2023, indicated R2 received services for medication management, showers, toileting, forgetfulness behaviors, morning and evening cares. R2's record included an initial admission assessment completed on November 10, 2022, and a 14-day assessment completed on November 30, 2022, which was past due by 6 days. R4 R4 admitted to the licensee on February 9, 2023,	01620		

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01620	Continued From page 34 for assisted living services. R4's diagnosis included type 2 diabetes mellitus, Alzheimer's dementia, anxiety, hypertension, and depression. R4's Service Plan Detail signed February 9, 2023, indicated R4 received blood glucose monitoring, laundry, medication administration, and housekeeping. R4's record included an initial assessment completed on February 9, 2023, and a 14-day nursing reassessment and monitoring completed March 2, 2023, which was past due by seven days. R5 R5 was admitted to the licensee on November 1, 2022, for assisted living services. R5's diagnosis included abnormal glucose, Atrial Fibrillation, macular degeneration of both eyes and hyperlipidemia. R5 Service Plan dated November 1, 2022, indicated R5 received services for housekeeping and reassurance checks. R5's record included an initial admission assessment completed on November 2, 2022, and a 14-day assessment completed on November 17, 2022, which was past due by one day. On June 7, 2023, at 11:14 a.m., clinical nursing supervisor (CNS)-A stated licensee was short staffed hence the late assessments. The licensee's Initial and On-going Nursing	01620		

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01620	Continued From page 35 Assessment of Residents policy dated August 1, 2021, indicated nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	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 medications according to provider orders for one of five residents (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	01760		

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01760	Continued From page 36	01760		

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's Service Plan signed June 20, 2019, indicated R1 received services for medication management and administration.

R1's provider order signed on February 16, 2023, and May and June 2023, electronic medication administration record (EMAR) indicated:
-take fluticasone 50 micrograms (mcg) nasal, instill one spray in each nostril twice daily for allergy symptoms.

Unlicensed personnel (ULP)-E's employee record included an Educare transcript (online training platform) which indicated medication training was completed on May 11, 2023. Further it included ULP-E's Copperfield Hill Skills/Competency test which indicated they passed Nasal Spray and Preparation for All Medication Administration (which included the 6 Rights) competencies on May 16, 2023.

On June 7, 2023, at 7:28 a.m., the surveyor observed ULP-E prepare and administer medications to R1. ULP-E administered two sprays of fluticasone 50mcg in each nostril.

On June 7, 2023, at 7:49 a.m., ULP-E was asked by surveyor to review R1's fluticasone order. ULP-E stated, "I should have read that closer." ULP-E stated they were a newer employee and it was their first time working the morning shift, they

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01760	Continued From page 37 primarily worked evenings. They stated they had received education for medication administration when hired but it felt sort of rushed. ULP-E stated they would report the medication error to the nurse per policy. The licensee's Medication Errors policy dated August 1, 2021, indicated: "A medication error occurs when: o Medication is given to the wrong client o The wrong medication is given o The wrong dose of medication is given o Medication is not given and not marked as held or otherwise appropriately on the MAR o Medication was not given within the parameters specified on the MAR or prescription o Medication given after discontinued/held o Missing medications o The controlled medication count is not accurate o There are gaps or errors on the MAR o A new prescription is not initiated properly o A medication refill was not ordered timely" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications	01910		

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01910	Continued From page 38 remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R7). 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: R7 was discharged from the licensee to a nursing home on February 1, 2023. R7's discharge record dated February 1, 2023,	01910		

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01910	Continued From page 39 indicated as per R7's last nursing assessment completed on October 25, 2022, R7 received the following medications: levothyroxine 125 microgram (mcg) take one tablet by mouth daily at 8:00 a.m., losartan pot 25 milligram (mg) take one tablet by mouth daily at 8:00 a.m., metoprolol succinct ER 50 mg take one tablet by mouth daily, sertraline 25 mg take three tablets by mouth daily, Tresiba flextouch 200 units/milliliter (u/ml) inject 60 units subcutaneously every morning, and vitamin D3 l000 iu (25 mcg) take one tablet by mouth twice daily. R7's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. On June 6, 2023, at 12:10 p.m., clinical nurse supervisor (CNS)-A stated they normally fill out a disposition record for any resident medication managed by licensee at discharge. CNS-A also stated R7's record slipped their mind until it was brought to their attention. The licensee's Disposition or Disposal of Medication policy dated August 1, 2021, indicated staff will document the disposition or disposal of medications in the resident ' s record using agency's electronic software. Documentation of the destruction, listing the date, quantity name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident's record for two years. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01910		

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01910	Continued From page 40 days	01910		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *06/06/23*
Time: 11:22:37
Report: 7994231128

Food and Beverage Establishment Inspection Report

Location:
Tff Care Llc
4200 40th Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0039076
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632771001
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.

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

PREP AREA HANDWASH SINK FOUND BLOCKED BY MOP BUCKET.

Comply By: 06/06/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

WALK IN COOLER FOUND WITH DETERIORATING FLOORS THAT WILL NEED TO BE REPLACED.

Comply By: 06/06/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISHWASHER FOUND NOT DISPENSING SANITIZER. ADJUST FILL WAND AND REPRIME SANITIZER.

Comply By: 06/06/23

Type: Full
Date: *06/06/23*
Time: 11:22:37
Report: 7994231128
Tff Care Llc

Food and Beverage Establishment Inspection Report

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

TEMPERATURES:
TOMATOES 40
HAM 39
EGG 148

SANITIZERS:
DISHWASHER 0 PPM CL
3 COMP SINK 400 PPM QUAT

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 7994231128 of 06/06/23.

Certified Food Protection Manager: Michael Caprarola

Certification Number: 75769 Expires: 02/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

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

Report #: 7994231128

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	1	**Date**	06/06/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:22:37
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Tff Care Llc	4200 40th Avenue North	Robbinsdale, MN	55422	7632771001

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0039076		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 06/06/23

Inspector (Signature) Crystal Elva