Electronically Delivered

July 21, 2023

Licensee
24 Seven Home Care Inc.
9120 Cambridge Avenue
Brooklyn Park, MN 55443

RE: Project Number(s) SL34709015

Dear Licensee:

On October 6, 2022, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 19, 2022, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Electronically Delivered

September 13, 2022

Administrator
24-Seven Home Care Inc
9120 Cambridge Avenue
Brooklyn Park, MN 55443

RE: Project Number(s) SL34709015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 19, 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 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $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,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34709	A. BUILDING: _____ B. WING _____	08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24 SEVEN HOME CARE INC	9120 CAMBRIDGE AVENUE BROOKLYN PARK, MN 55443

(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: SL#34709015 On August 15 through August 19, 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 four (4) 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 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 144G.31 subd. 1, 2, and 3.	
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements	0 485		

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0 485	Continued From page 1 (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: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee required residents to pay for meals in their assisted living contract for one of one resident (R1) with record reviewed. 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:	0 485		

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0 485	Continued From page 2 On August 15, 2022, at approximately 1:00 p.m., director (D)-C provided a blank Assisted Living Agreement document identified as licensee's assisted living contract, and indicated all residents are required to sign the contract at the time of move in. On page one (1) of licensee's Assisted Living Agreement, the licensee indicated three meals per day plus snacks would be provided to residents. On August 16, 2022, at approximately 12:00 p.m., D-C indicated all residents received the licensee's meal plan and no option to decline meals was available to residents. D-C stated all residents paid for meals once an assisted living contract was signed and licensee did not offer an "opt out" option for meals. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, indicated all residents would sign licensee's assisted living contract and was a legal, binding contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
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:	0 780		

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0 780	Continued From page 3 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the interconnection of required smoke alarms. This has the potential to directly affect resident(s), staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 17, 2022, approximately from 10:15 a.m. to 10:40 a.m. and from 12:25 p.m. to 12:30 p.m., survey staff toured the home with the	0 780		

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0 780	Continued From page 4 unlicensed personnel (ULP)-D, and from approximately 10:40 a.m. to 12:25 p.m., the ULP-D was replaced with the director (D)-C. During the tour with the D-C, survey staff observed the home consisted of multiple brands of smoke alarms, and when the D-C tested the smoke alarm in resident bedroom #1 and other required smoke alarms throughout the home, the smoke alarms were not interconnected. Survey staff explained to the D-C that when one alarm is activated, all smoke alarms must sound throughout the home. The D-C verified the findings and commented that he thought his maintenance staff took care of the interconnection of the home ' s smoke alarms. On August 17, 2022, at approximately 1:00 p.m., during the exit interview, the D-C, the registered nurse-A, and the unlicensed personnel-E acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790		

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0 790	Continued From page 5 Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. 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 17, 2022, approximately from 10:15 a.m. to 10:40 a.m. and from 12:25 p.m. to 12:30 p.m., survey staff toured the home with the unlicensed personnel (ULP)-D, and from approximately 10:40 a.m. to 12:25 p.m., the ULP-D was replaced with the director (D)-C. During the tour with the D-C, survey staff observed the portable fire extinguishers were provided with an annual service date of October 2021 but lacked records to show the monthly visual inspections date for this year and last year. Survey staff explained to the D-C that the portable fire extinguishers must also be provided with monthly visual inspection or "quick checks" of each extinguisher by staff to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no	0 790		

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0 790	Continued From page 6 obvious physical damage or condition to the extinguisher to prevent their operation when needed. If extinguishers were comprised or questionable, they will need to get them to a vendor for servicing such as recharging or maintenance. On August 17, 2022, at approximately 1:00 p.m., during the exit interview, the D-C, the registered nurse-A, and the unlicensed personnel-E acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800		

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0 800	Continued From page 7 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 is 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 are: On August 17, 2022, approximately from 10:15 a.m. to 10:40 a.m. and from 12:25 p.m. to 12:30 p.m., survey staff toured the home with the unlicensed personnel (ULP)-D, and from approximately 10:40 a.m. to 12:25 p.m., the ULP-D was replaced with the director (D)-C. Survey staff observed the following findings during the tour: 1) The clothes washer had a leak as staff noticed water on the floor. The ULP-D stated that someone was coming to fix it. 2) A large trash bag was placed on the cover of one of the window wells for the lower-level bedrooms. The ULP-D stated she thought maybe the contractor had left it there. 3) The rainwater downspout was disconnected from the hung scupper/gutter system. In addition, the downspout was missing an extension piece to carry water away home the home ' s foundation to prevent water intrusion. 4) The furnace filter was layered with thick dust build-up. The D-C verified the finding as he replaced the filter while on tour. 5) The upstairs bathroom lower wall (sheetrock) behind the toilet was comprised near the floor where water from the use of the shower or toilet overflows to prevent water intrusion into the wall and cleanability of the wall/floor. 6) The upstairs unoccupied bedroom (#4) was	0 800		

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0 800	Continued From page 8 asked to be opened during the tour and the D-C failed to find the key to enter the room. The D-C explained that the room was currently not occupied and therefore, it was used more for storage, and that the health surveyor used the room from the day before. Survey staff explained that all resident bedrooms must have keys available by staff on duty for ready access in case of resident emergency and needing assistance. The D-C made a phone call and within approximately 20 minutes the registered nurse (RN)-A and the unlicensed personnel (ULP)-E arrived on site and opened the door. The D-C also commented that the bedroom was not occupied and therefore, they did not have the key readily available. 7) The main level bathroom shower/tub had comprised sealant that needed to be repaired to prevent water intrusion and cleanability between the cracks to prevent potential growth of mold and bacteria over time. 8) The lower-level resident bedroom #2 window was missing a window screen. 9) The windows in the lower-level resident bedrooms #2 and #3 failed to work in the correct manner. The bottom of the windows had a screw installed preventing the D-C to open the egress window on the right window pane where there was a dedicated handle. The D-C attempted again by opening the left window pane of both rooms and was able to completely open the left pane of the windows for bedrooms #2 and #3. All egress windows must be easily operable for an immediate opening during a fire or similar emergency, and the installed screws create impediment and confusion to the proper use of the egress windows. 10) An electrical outlet in the laundry room was missing a wall cover plate. The D-C stated that the cover plates were removed due to recent	0 800		

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0 800	Continued From page 9 painting. Survey staff explained that all electrical outlets with missing wall covers must be provided with a cover plate. On August 17, 2022, at approximately 1:20 p.m., during the exit interview, the D-C, the RN-A, and the ULP-E acknowledged the findings. No Further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

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0 810	Continued From page 10 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 observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 17, 2022, at approximately 11:40 a.m., survey staff advised the D-C and the unlicensed personnel (ULP)-E while touring the dining room that survey staff will need to review the home ' s fire safety and evacuation documentation, the evacuation drill, and the training documentation after the tour of the home. The ULP-E stated that the requested information was in a binder and was on site yesterday but was taken back to their	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34709	A. BUILDING: _____ B. WING _____	08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24 SEVEN HOME CARE INC	9120 CAMBRIDGE AVENUE BROOKLYN PARK, MN 55443

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0 810	Continued From page 11 other office as they thought it was no longer needed. Survey staff asked the ULP-E to retrieve the requested documentation from their other office for review. The ULP-E left the home and came back within approximately 30 minutes with the requested documentation. The review of the documentation indicated the following findings: FIRE SAFETY AND EVACUATION PLAN 1) The plan documentation 9.07 (fire policy), dated, 8/1/2021, lacked fire protection procedures necessary to address unique resident-specific situations during an evacuation. Unique situations that must be considered during an evacuation could be residents who have mobility limitations, cognitive impairment, or any residents needing assistance during an evacuation and must be addressed in the fire safety and evacuation plan. 2)The evacuation floor plan incorrectly showed the garage as an approved exit, inconsistent labeling of the upstairs bedroom as an office rather than a bedroom, and incorrectly labeled a room next to resident bedroom #1 on the main floor as a bedroom when the D-C stated that it was not a bedroom. 3) The licensee failed to have the home ' s fire safety and evacuation plan readily available on site. EVACUATION DRILLS A review of drill records indicated licensee failed to show compliance with the minimum number of required employee fire and evacuation drills performed to date for a minimum of two drills per year per shift with at least one drill every other month for a minimum of six evacuation drills per year. The review of the drill records showed employee drills performed were, on October 13, 2021, at 4:30 p.m. and November 30, 2021, at 12:30 a.m. The records did not comply with the	0 810		

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0 810	Continued From page 12 minimum frequency of one drill every other month and a minimum of six total drills in a year. On August 17, 2022, at approximately 1:20 p.m., during the exit interview, the director (D)-C, the registered nurse (RN)-A, and the ULP-E acknowledged the findings. The D-C and the RN-A stated that they performed drills monthly. Survey staff stated that additional drill records may be considered for further consideration if provided by the end of the following day (August 18, 2022) for review. Additional drill records were received from the D-C via email on August 18, 2022, at 11:11 a.m.: 1) October 13, 2021, at 4:30 p.m. and 6:05 p.m., 2) November 30, 2021, at 12:30 a.m. and 3:00 p.m., and 3) April 4, 2022, at 4:00 p.m. and 7:00 p.m., The drill records received failed to meet the minimum required frequency of drills performed by employees every other month. It is also noted that the drill records received via email did not document the facility name and address, and all records should have the information included for clarity. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any	0 820		

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0 820	Continued From page 13 existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee had an egress window for the resident bedroom #1 on the main floor which could not be opened, had unsafe use of double-keyed deadbolt hardware on the egress side of the front door and patio sliding door, and had double-keyed deadbolt hardware on all doors in the home including resident room doors. This had the potential to affect all residents, staff, and visitors because timely evacuation would not be possible in the event of a fire, hostile intruder, or other life-threatening emergencies. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 17, 2022, from 10:15 a.m. to 10:40 a.m., and from 12:25 p.m. to 12:30 p.m., survey staff toured the home with the unlicensed	0 820		

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0 820	Continued From page 14 personnel (ULP)-D, and from approximately 10:40 a.m. to 12:25 p.m., ULP-D was replaced with director (D)-C. During the tour, survey staff observed the following: At approximately 10:50 a.m., survey staff observed double-keyed deadbolt hardware that required a key to lock and unlock the doors from the interior of the home including resident room doors. Survey staff asked D-C about the double-keyed deadbolt hardware. D-C explained that the previous resident in resident bedroom #1 had dementia and had to be secured from resident elopement, but that resident has been discharged. D-C also stated the deadbolt locks (double-keyed) on doors were necessary because the current residents had high risks of elopement due to mental illness and the locks are utilized as an elopement prevention measure. D-C also stated that all staff carry keys 24 hours a day. At approximately 11:00 a.m., survey staff asked D-C to open the window in resident bedroom #1 on the main floor for measurement. D-C found out he was not able to open the window when he attempted. Survey staff and D-C observed two screws installed on the bottom of the window preventing the window from being opened. Survey staff explained to D-C that the window must be available for immediate use during a fire or similar emergency for safe egress. The screws prevent the window from being readily operable for immediate use. D-C verified the finding. At approximately 12:28 p.m., survey staff observed two double-keyed deadbolt hardware installed on the primary entrance door and a security chain above the deadbolts. Survey staff asked ULP-D to open the front door. ULP-D used	0 820		

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0 820	Continued From page 15 a key to open the lower deadbolt and opened the front door. Survey staff asked ULP-D if the other deadbolt was ever used, and ULP-D stated that (the key) was on a different set of keys. On August 17, 2022, at approximately 1:30 p.m., during the exit interview, survey staff explained to D-C, registered nurse (RN)-A, and ULP-E that a distinct hazard order was issued for the above findings. Survey staff explained that the locks in the means of egress that require a key will cause delay and impediment in proper exiting of the home or a room during a fire or similar emergency and violate state codes. RN-A stated her understanding was locks may be used if the staff was provided with keys for exiting. In addition, RN-A explained that they have three staff at all times including the night shift. She stated her concerns were beyond resident elopement and they were protecting the community as they were dealing with mental health issues. She also added that they can remove all locks right away but that poses a threat to the community. Survey staff commented that it is the responsibility of the licensee to come up with an acceptable plan to address resident safety as well as other concerns they may have with the community. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 970 SS=C	144.50 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 16 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 a waiver of liability for one of one resident (R1) with record reviewed. This practice resulted in a level one 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 15, 2022, at approximately 1:00 p.m., director (D)-C provided a blank Assisted Living Agreement document identified as the licensee's assisted living contract, and indicated all residents are required to sign the contract at the time of move in. On page thirteen (13) under VIII. Miscellaneous Provisions, section A. Insurance Liability and Release, the contract indicated the resident was required to maintain insurance for personal property, liability, and was responsible for their own heath. Additionally, the contract read, "The Resident acknowledges that 24-Seven Homecare is not an insurer of the Resident's person or property."	0 970		

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0 970	Continued From page 17 On August 16, 2022, at approximately 12:00 p.m., D-C indicated all residents must sign and agree to licensee's assisted living contract as identified. D-C stated the residents were responsible for their own safety and personal property and licensee would not be responsible for either. D-C acknowledged, after reviewing statute, this section could be considered the licensee waiving liability for health and safety, and personal property of the residents. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, indicated all residents would sign licensee's assisted living contract and was a legal, binding contract. No further information 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 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	01440		

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01440	Continued From page 18 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 30-day supervision of delegated task to an unlicensed staff as required for one of one unlicensed personnel (ULP)-B with record reviewed. 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: ULP-B was hired on January 1, 2021. ULP-B's Home Health Aide Medication Competency Evaluation dated January 9, 2021, indicated ULP-B was considered competent in the administration of medications. ULP-B's record lacked supervision of medication administration competency within 30 calendar	01440		

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01440	Continued From page 19 days after the task was delegated to ULP-B. On August 16, 2022, at approximately 12:00 p.m., RN-A acknowledged ULP-B's record lacked documentation of a 30-day supervision for the delegated task of medication administration. RN-A stated ULPs are supervised monthly by the RN, but documentation of direct supervision within 30 calendar days related to medication administration would not be included in ULP-B's record. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated direct supervision of delegated task would be conducted within 30 calendar days of delegation and documentation of supervision would be included in the employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01440		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 20 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include a written statement of a treatment service on the resident's service plan for one of one resident (R1) with record reviewed. 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 admitted to licensee on September 3, 2019. R1's Assessment by Date dated July 12, 2022,	01940		

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01940	Continued From page 21 indicated R1 required a treatment for the use of a continuous positive airway pressure (CPAP), a device applied and used at night to maintain airways open while a person sleeps. Staff were to assist in applying the device at night, monitor it is working correctly, and document on R1's sleeping patterns when using it. R1's Service Plan (Waiver) - Addendum to Contract dated July 30, 2021, lacked identification of treatment services related to R1's CPAP. On August 16, 2022, at approximately 12:00 p.m., registered nurse (RN)-A acknowledged R1's service plan lacked identification of the treatment service for R1's CPAP. RN-A stated it was an oversite by the licensee, but all components of a treatment plan for the CPAP were implemented and provided. RN-A stated the service would need to be added and a new service plan agreement signed and maintained in R1's record. The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2021, indicated all treatments or therapy services would be included on each respective resident's service plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		

Minnesota Department of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/15/22*
Time: 12:30:00
Report: 1013221238

Food and Beverage Establishment Inspection Report

Location:
24 Seven Home Care Inc
9120 Cambridge Avenue
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038454
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128862828
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Eggs
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator B. Mueller.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, granite counter tops, wood floor, tile back splash, and a painted ceiling. The kitchen finishes and surfaces were well maintained. When updated the ceiling and floor need to be smooth, durable, easily cleanable, and nonabsorbent.

A 2 basin sink is located in the kitchen. One basin must be designated for hand washing.

A residential dish machine is located in the kitchen. The sanitize and high temp cycles are used for washing ware.

Type: Full
Date: *08/15/22*
Time: 12:30:00
Report: 1013221238
24 Seven Home Care Inc

Food and Beverage Establishment Inspection Report

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, date marking, cleaning, serving highly susceptible populations, and food handling procedures.

Food safety guidance documents were emailed.

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 1013221238 of 08/15/22.

Certified Food Protection Manager: Ovie Avwenaghagha

Certification Number: 107172 Expires: 08/01/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ovie Avwenaghagha
Operator

Signed: JM

Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us