Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 10, 2024

Licensee
First Choice Nursing Services Inc
5500 81st Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35250015

Dear Licensee:

On September 6, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 27, 2024, survey were corrected. This follow-up survey verified that the facility is n substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

July 31, 2024

Licensee
First Choice Nursing Services Inc.
5500 81st Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35250015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 27, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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. 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 . . ."

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 may be 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.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 MDH within 15 calendar days of the correction order receipt date.

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

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

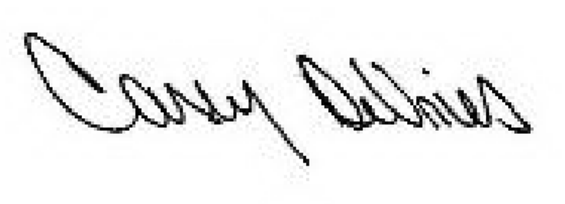
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH 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 ******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: SL35250015-0 On June 24, 2024, through June 27, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; all of whom were receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 24, 2024, at 10:31 a.m., during the	0 460		

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0 460	Continued From page 2 entrance conference, agent (A)-A stated, "All our residents are able to call for help. We just found out we needed to have something so we are trying to see what will work for us, if we can just use a bell or someone was telling me this weekend there is a call system you can plug in and they push it and it calls for help." On June 26, 2024, at 10:22 a.m., the registered nurse/licensed assisted living director (RN/LALD)-C acknowledged the licensee lacked a system the residents could use to summon assistance and stated, "We are aware but that is not in place at this point yet." On June 26, 2024, at 11:10 a.m., during a facility tour, the surveyor observed a rambler style home with a basement with two resident rooms located on the main level and three resident rooms located on the lower level. In addition, the surveyor observed no bells, call lights, or pendants provided for the residents to summon assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required	0 470		

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0 470	Continued From page 3 by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor in accordance with Minnesota Administrative Rule 4659.0180 Subpart 3., at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 470		

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0 470	Continued From page 4 affect a large portion or all of the residents). The findings include: On June 24, 2024, at 10:43 a.m., during the entrance conference, agent (A) - A acknowledged they did not develop and implement a written staffing plan twice a year, and stated, "That is one part we have not yet done, because that is an on-going thing based on our needs we just look at each week to see what we need." The licensee's 4.06 Staffing & Scheduling policy dated October 11, 2021, read, "The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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.	0 480		

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0 480	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 25, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national 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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510		

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0 510	Continued From page 6 by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control, by not cleaning shared equipment, and not performing appropriate hand hygiene, for one of three employees (unlicensed personnel (ULP)-G). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-G began employment with the licensee and started providing assisted living services January 3, 2024. On June 25, 2024, at 7:29 a.m., the surveyor observed ULP-G entered the dining room wearing gloves and obtained vital signs for R1. Without performing hand hygiene (HH), ULP-G changed gloves. ULP-G did not clean the vitals equipment after use. ULP-G then used the equipment to obtain vital signs for R2. ULP-G did not clean the equipment after use on R2, and put the equipment away. On June 25, 2024, at 10:56 a.m., ULP-G stated, "It's the nurse that cleans that. I think she comes on Wednesdays." Asked if she ever cleans them between residents, ULP-G stated, "No". Asked if	0 510		

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0 510	Continued From page 7 she was trained to clean the equipment between residents, ULP-G replied, "No. It is strictly the nurse who cleans them." On June 26, 2024, at 10:26 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "When you complete the cares on one person, before going to the next, you should change your gloves. Immediately after you use it, like the blood pressure cuff, you should wipe it down after using it. It is not once a week, it is each use, and of course as a nurse I know that, but it is staff that needs to know that." The licensee's 8.07 Gloves policy dated November 1, 2021, read, "gloves must be worn whenever there may be direct contact between an employee and contaminated objects or as instructed. PROCEDURE: 1. Wash hands 2. Apply gloves to both hands 3. Remove contaminated materials 4. Place materials and proper receptacle 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out. 6. Dispose used gloves improper receptacle. 7. Rewash hands." The surveyor requested but was not provided with a policy that identified when shared equipment would be cleaned. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 630	Continued From page 8	0 630		
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 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 three of three residents (R1, R2, and R3). 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 R1's Service Plan, signed by R1 on January 5, 2024, indicated R1 received services including assistance with meals, medication administration,	0 630		

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0 630	Continued From page 9 vital signs, and diabetic management including blood glucose monitoring. R1's record included a Vulnerability Assessment dated January 5, 2024, of the resident's susceptibility to abuse by other individuals and risk of abusing other vulnerable adults or minors, however it lacked the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. R2 R2's Service Plan, signed by R2 on April 17, 2024, indicated R2 received services including assistance with dressing, oral care, bathing, shaving, foot care, skin care, stand by assist with transfers, meals, medication administration, vital signs, and behavior monitoring. R2's record included a Vulnerability Assessment dated April 17, 2024. The assessment lacked a review of the resident's susceptibility to abuse by other individuals and risk of abusing other vulnerable adults or minors, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. R3 R3's Service Plan, signed by R3 on August 1, 2023, indicated R3 received services including assistance with dressing, bathing, meals, medication administration, and vital signs. R3's record included a Vulnerability Assessment dated August 1, 2023, of the resident's susceptibility to abuse by other individuals and risk of abusing other vulnerable adults or minors, however it lacked the specific measures to be taken to minimize the risk of abuse to the resident	0 630		

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0 630	Continued From page 10 or other vulnerable adults and risk of self-abuse. On June 26, 2024, at 10:35 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "I know the column should say take it to the care plan, if they are at risk there are things that should be addressed, and it should be in the care plan. If it's not there, I don't know. I know it should be addressed I agree." The licensee's 6.05 Individual Abuse Prevention Plan policy, dated November 1, 2021, read, "1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center	0 640		

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FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH 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
0 640	Continued From page 11 to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 24, 2024, at 10:00 a.m., the surveyor observed no 911 emergency number posted near the community telephone in the living room. On June 26, 2024, at 10:41 a.m., registered nurse/licensed assisted living director (RN/LALD)-C acknowledge the phone in the living room was used by residents and staff and the posting for 911 was not visible from the phone, and she stated, "So technically it should be by the phone. I will fix that right away." No further information was provided.	0 640		

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0 640	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity 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 observation, interview, and record review, the licensee failed to establish and 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 current facility TB risk assessment. The licensee also failed to ensure screenings for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of two employees, (unlicensed personnel(ULP)-B and ULP-E). This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 13 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: TB RISK ASSESSMENT On June 24, 2024, at 12:20 p.m., agent (A)-A provided the surveyor with the licensee's TB risk assessment dated November 1, 2021. On June 26, 2024, at 10:43 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "We should be updating it every two years, I did go through it and update the survey binder last night and I did update this one and put it in." SCREENING ULP-B was hired May 22, 2023, to provide direct cares and services to residents. On June 25, 2024, at 12:05 p.m., the surveyor observed ULP-B assist R2 with blood glucose monitoring. ULP-E was hired November 30, 2022, to provide direct cares and services to residents. ULP-B and ULP-E's employee records lacked evidence of screening for active TB with either a two-step TST or blood test. On June 26, 2024, at 10:43 a.m., RN/LALD-C stated the screening for active TB was,	0 660		

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0 660	Continued From page 14 "something we still need to do at this point." The Licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, read, "the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health." As well as "Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tools for HCW's. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results from the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 15 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. 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).	0 680		

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0 680	Continued From page 16 The findings include: The licensee's emergency disaster preparedness plan dated August 1, 2021, lacked annual review, and evidence of the following required content: -address the following whether evacuated or shelter in place for staff/residents: -food, water, medical supplies, pharmaceutical supplies, and alternate sources of energy to maintain: -temperatures to protect resident health/safety; -safe/sanitary storage of provisions; -emergency lighting; -fire detection, extinguishing, alarm systems; and -sewage and waste disposal; -develop policies/procedures (P/P) to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP and must include the following: -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility- based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan	0 680		

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0 680	Continued From page 17 as needed. On June 26, 2024, at 10:45 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "I know that is not here [completed] at this point I agree, we do have an emergency kit but not all that stuff is completed at this point so we will need to look at that too." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	0 780		

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0 780	Continued From page 18 except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 24, 2024, at 10:30 a.m., survey staff toured the facility with agent (A)-A. Survey staff tested the smoke alarms throughout the home. It was observed that the smoke alarm in bedroom #4 was not interconnected with the rest of the facility. These deficient conditions were visually verified by A-A accompanying on the tour. During interview on June 27, 2024, at 1:00 p.m., A-A stated they understood the requirement for the smoke alarms. TIME PERIOD FOR CORRECTION: Seven (7)	0 780		

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0 780	Continued From page 19 days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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. 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). The findings include: On June 24, 2024, at 10:30 a.m., survey staff toured the facility with agent (A)-A. The following	0 800		

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0 800	Continued From page 20 was observed. Egress Windows: It was observed that the window lever in bedroom #3 was broken and the window could not be opened. The room was unoccupied at the time of inspection due to the resident who usually lives in that room being at the hospital with no expected return date. It was observed that the window well and window well cover of bedroom #4 were overgrown with vines, shrubs, and other weeds. The window was obstructed from opening completely due to the overgrowth of plants. The window well cover was difficult to lift out of the way completely due to the plants growing across the top. Egress windows must be provided, have a clear path of access, and be properly maintained to allow for the proper function in buildings not equipped with an automatic sprinkler system. General Maintenance: It was observed that bedroom #3 had multiple locations where the walls had been damaged. There was a hole behind the door where the door knob broke the drywall. There was floor trim missing and the wall was damaged adjacent to the closet. It was observed that the bathroom adjacent to bedroom #3 had water damage on the wall by the back of the tub. The paint was peeling and a hole was started in the drywall. It was observed that the basement living room had significant damage and staining to the wood trim where the carpet met the white tile floor. It appeared to be water damage, but A-A did not	0 800		

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0 800	Continued From page 21 know what could have caused it. It was observed that there was a large rusted pipe sticking out of the ground on the side of the house where the garbage bins were being stored. The pipe was approximately six (6) inches in diameter, had rusted, jagged edges, and extended from the ground to approximately 18 inches. A-A stated they did not know what the pipe could be, but would investigate to see if it could be removed or capped. During interview on June 27, 2024, at 1:00 p.m., A-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 22 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 24, 2024, agent (A)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and	0 810		

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0 810	Continued From page 23 evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety and Evacuation", undated, lacked the following: The FSEP included standard employee procedures but lacked specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but lacked specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on June 27, 2024, at 1:00 p.m., A-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.	0 810		

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0 810	Continued From page 24 TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. A-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. A-A was unable to provide documentation showing any training offered or training scheduled for a future date for staff on the fire safety and evacuation plan. During an interview on June 27, 2024, at 1:30 p.m., A-A stated they understood the requirements and would implement a training program that was compliant with statute requirements DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evidenced by the fire drill reports provided. Evacuation drills were conducted on June 15, 2024, and March 15, 2024. No other documentation was provided. During an interview on June 27, 2024, at 1:00 p.m., A-A stated there were no additional documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH BROOKLYN PARK, MN 55443

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0 820	Continued From page 25	0 820		
0 820 SS=F	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 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 fire-rated ashtrays for resident use in smoking areas. 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) 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 June 24, 2024, at 10:30 a.m., survey staff toured the facility with agent (A)-A. It was observed that the attached garage was being used as a smoking area. There was no ashtray	0 820		

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0 820	Continued From page 26 provided in the garage for residents to extinguish and discard their cigarette butts. The garage was also being used as a storage space. Cardboard boxes were stacked floor-to-ceiling along the back wall of the garage, two gasoline-powered push mowers, a large ACE garbage bin, Kingsford grill charcoal, lighter fluid, and a variety of other miscellaneous, combustible items stored immediately adjacent to the couch that residents used while smoking. Survey staff explained to A-A that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if they were not completely extinguished before residents discarded them on the garage floor or in another receptacle that was not present at the time of survey. A-A visually verified these deficient findings at the time of discovery. During interview on June 27, 2024, at 1:00 p.m., A-A stated there was a designated smoking area outside of the garage, but residents were not using it. Survey staff did not see any other area with a proper disposal receptacle at the time of the survey. A-A stated they understood the hazards observed in the smoking area and would get the garage cleaned out and encourage the residents to use the designated smoking area outside the garage. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	0 970		

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0 970	Continued From page 27 liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or 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 licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee and began receiving assisted living services on January 5, 2024. R2 was admitted to the licensee on September 12, 2019, and began receiving assisted living services on August 1, 2021. R1 and R2's records included a [Licensee] Assisted Living Contract, signed on January 5, 2024, and April 17, 2024, respectively, which	0 970		

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0 970	Continued From page 28 included the following language, indicating a waiver of liability: "Indemnification: [Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any partthereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely by negligence of [Licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On June 26, 2024, at 10:47 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "I have never read it that closely. Ok. Well, we can get that fixed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	01060		

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01060	Continued From page 29 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency	01060		

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01060	Continued From page 30 relocation greater than four days for one of one resident (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) 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: R2 was admitted to the licensee on September 12, 2019, and began receiving assisted living services on August 1, 2021. R2's Service Plan, signed April 17, 2024, indicated R2 received services including assistance with dressing, oral care, bathing, shaving, foot care, skin care, stand by assist with transfers, meals, medication administration, vital signs, and behavior monitoring. R2's Progress Notes, dated March 7, 2024, through March 11, 2024, indicated R2 had been in the hospital from March 7, 2024, through March 11, 2024. R2's record lacked evidence a written notice, with the required statutory content, was provided to resident, or resident representative. On June 25, 2024, at 11:10 a.m., the surveyor asked the agent (A)-A if an emergency relocation form had been completed or sent to the OOLTC for R2's most recent hospitalization. A-A stated, "We did not relocate [R2] so there is no relocation form. He went to the hospital, so we did not	01060		

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01060	Continued From page 31 relocate him. Why would he need a relocation form? This is the first I am learning of this. We do not do this." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) prior to staff providing services for one of one unlicensed personnel (ULP)-M. In addition, the licensee failed to ensure a background study was submitted and received in affiliation with the	01290		

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01290	Continued From page 32 assisted living license for nine of twenty employees (ULP-E, ULP-H, ULP-I, ULP-J, ULP-K, ULP-L, ULP-N, and house manager (HM)-F). This had the potential to affect all five residents residing in the assisted living facility and resulted in an immediate correction order on June 25, 2024, at approximately 3:15 p.m. 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 the potential to affect a large portion or all the residents). The findings include: ULP-M was hired May 9, 2024, to provide direct care. On June 24, 2024, at 2:40 p.m., HM-F provided the surveyor with the licensee's weekly schedule for June 17, 2024, through June 30, 2024, which indicated ULP-M worked on June 21, 2024, from 3:00 p.m. to 11:00 p.m. ULP-M's employee record lacked evidence of a cleared background study as required. On June 24, 2024, at 12:56 p.m., agent (A)-A emailed the surveyor indicating A-A was not able find ULP-M's cleared background study through NETStudy as required. Via email, A-A wrote, "[ULP-M] BG expired so I redid it. Find it attached." ULP-E	01290		

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01290	Continued From page 33 ULP-E was hired on November 30, 2022, to provide direct care. The Licensee's NETStudy 2.0 record included a background study clearance for ULP-E dated, November 28, 2022, affiliated to a sister facility, HFID 28880. ULP-E's record lacked evidence the licensee submitted a background study for ULP-E under the current assisted living license and affiliated to the licensee's HFID number. ULP-G ULP-G was hired on January 3, 2024, to provide direct care. The Licensee's NETStudy 2.0 record included a background study clearance for ULP-G dated, October 14, 2022, affiliated to a sister facility, HFID 33987. ULP-G's record lacked evidence the licensee submitted a background study for ULP-G under the current assisted living license and affiliated to the licensee's HFID number. ULP-H ULP-H was hired on June 6, 2024, to provide direct care. The Licensee's NETStudy 2.0 record included a background study clearance for ULP-H dated, June 6 2024, affiliated to a sister facility, HFID 28880. ULP-H's record lacked evidence the licensee submitted a background study for ULP-H under the current assisted living license and affiliated to the licensee's HFID number. ULP-I ULP-I was hired on January 4, 2024, to provide direct care. The Licensee's NETStudy 2.0 record included a	01290		

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01290	Continued From page 34 background study clearance for ULP-I dated, January 4, 2024, affiliated to a sister facility, HFID 33145. ULP-I's record lacked evidence the licensee submitted a background study for ULP-I under the current assisted living license and affiliated to the licensee's HFID number. ULP-J ULP-J was hired on January 19, 2024, to provide direct care. The Licensee's NETStudy 2.0 record included a background study clearance for ULP-J dated, January 9, 2024, affiliated to a sister facility, HFID 33145. ULP-J's record lacked evidence the licensee submitted a background study for ULP-J under the current assisted living license and affiliated to the licensee's HFID number. ULP-K ULP-K was hired on February 10, 2023, to provide direct care. The Licensee's NETStudy 2.0 record included a background study clearance for ULP-K dated, June 11, 2024, affiliated to a sister facility, HFID 28880. ULP-K's record lacked evidence the licensee submitted a background study for ULP-K under the current assisted living license and affiliated to the licensee's HFID number. ULP-L ULP-L was hired on June 1, 2023, to provide direct care. The Licensee's NETStudy 2.0 record included a background study clearance for ULP-L dated, August 11, 2022, affiliated to a sister facility, HFID 28880. ULP-L's record lacked evidence the licensee submitted a background study for ULP-L	01290		

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01290	Continued From page 35 under the current assisted living license and affiliated to the licensee's HFID number. ULP-N ULP-N was hired by the licensee to provide direct care. Despite repeated requests to the licensee, the surveyor was unable to determine ULP-N's date of hire. The Licensee's NETStudy 2.0 record included a background study clearance for ULP-N dated, June 7, 2024, affiliated to a sister facility, HFID 33987. ULP-N's record lacked evidence the licensee submitted a background study for ULP-N under the current assisted living license and affiliated to the licensee's HFID number. HM-F HM-F was hired by the licensee to provide direct care. Despite repeated requests to the licensee, the surveyor was unable to determine HM-F's date of hire. The Licensee's NETStudy 2.0 record included a background study clearance for HM-F dated, June 11, 2024, affiliated to a sister facility, HFID 28880. HM-F's record lacked evidence the licensee submitted a background study for HM-F under the current assisted living license and affiliated to the licensee's HFID number. On June 25, 2024, at 2:35 p.m., the surveyor asked A-A to update the employee list again as it was missing HM-F, ULP-N, A-A, LALD-C, and CNS-D. A-A stated, "Why do you need this info? Why do you need me on the employee list for example? Or [CNS-D]?" The surveyor requested the employee roster be updated to include all staff, titles, and hire dates on June 24, 2024, at 9:05 a.m., 11:02 a.m., 11:49 a.m., and 1:04 p.m.,	01290		

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01290	Continued From page 36 via email, and on June 25, 2024, at 9:12 a.m., 10:54 a.m., and 1:05 p.m., via email, and 2:35 p.m., in person. The licensee's 4.02 Background Studies policy dated November 1, 2021, read, "No employee may provide direct services and have independent direct contact with any residents until acceptable results of the background study have been received." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01500 SS=F	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;	01500		

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01500	Continued From page 37 (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 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 observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH 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
01500	Continued From page 38 (unlicensed personnel (ULP)-B and ULP-E). 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 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 include: ULP-B ULP-B was hired May 22, 2023, to provide direct cares and services to residents. On June 25, 2024, at 12:05 p.m., the surveyor observed ULP-B assist R2 with blood glucose monitoring. ULP-E ULP-E was hired November 30, 2022, to provide direct cares and services to residents. ULP-B and ULP-E's employee records lacked evidence annual training had been completed as required in the following areas: - reporting maltreatment of vulnerable adults; - assisted Living Bill of Rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning/service	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH 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
01500	Continued From page 39 delivery. On June 26, 2024, at 3:00 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "We have done this before [annual training], but we don't have the documentation, which is what I know you need so that will be corrected also. I am not going to pretend that I can give you that [training documentation] because I can't." The licensee's 5.06 Annual Required Staff Training policy dated November 1, 2021, indicated all staff providing services to residents would complete eight hours of annual training for every twelve months of employment, and would cover the above-mentioned topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH 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
01540	Continued From page 40 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame for two of two employees (unlicensed personnel (ULP)-B and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired May 22, 2023, to provide direct cares and services to residents. ULP-E was hired November 30, 2022, to provide direct cares and services to residents. ULP-B and ULP-E's employee records lacked evidence of the initial eight hours, or annual training hours in the required dementia care topics. On June 25, 2024, at 8:19 a.m., agent (A)-A stated, "We were doing dementia training before the license changed, but once the license changed, we thought we didn't need to do it since	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH 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
01540	Continued From page 41 we are assisted living, so we did not do dementia training after that." The licensee's 5.03 Dementia Training policy, dated November 1, 2021, read, "All staff of [Licensee] are required to complete dementia training at the time of hire and annually thereafter." The policy further indicated, "Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
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 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH 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
01620	Continued From page 42 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool per Minnesota Rule 4659.0150 for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee and began receiving assisted living services on January 5, 2024. R1's Service Plan, signed by R1 on January 5, 2024, indicated R1 received assistance with meals, medication administration, vital signs, and diabetic management including blood glucose monitoring. On June 25, 2024, at 7:29 a.m., the surveyor observed unlicensed personnel (ULP)-G	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH 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
01620	Continued From page 43 administer medications and obtain vital signs for R1. R1's 14-day reassessment, titled Monitoring and Reassessment, dated January 19, 2024, and R1's ongoing 90-day reassessment, titled Monitoring and Reassessment, dated April 17, 2024, lacked content required on the uniform assessment tool including a full physical and cognitive assessment. On June 26, 2024, at 9:25 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "We were told some of our assessments didn't meet the requirements at our last house (a sister facility that had been surveyed), because we use this (licensee's Monitoring and Reassessment form) for all our assessments when we are not doing the big (comprehensive) assessment, if we need to start doing the big comprehensive assessment going forward then I guess that is what we will need to do." The licensee's 6.01 Assessments, Reviews & Monitoring policy, dated November 1, 2021, read, "The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH 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
01880	Continued From page 44	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription and over the counter (OTC) medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 24, 2024, from 10:00 a.m., through 3:00 p.m., the surveyor observed three staff, three residents and two visitors throughout the common areas with direct access to the open floor plan dining room. On June 24, 2024, at 11:26 a.m., the surveyor observed an open, unlocked glass front cupboard in the facility kitchen/dining room. The cupboard contained one bottle of children's ibuprofen, one	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH BROOKLYN PARK, MN 55443

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01880	Continued From page 45 bottle of Nystatin topical powder, and a third, unlabeled bottle of powder. The medications all lacked a label identifying for whom the medications were intended. The medications were left unattended as the staff conducted other tasks throughout the facility. On June 24, 2024, at 11:26 a.m., unlicensed personnel (ULP)-E stated, "I am unsure why those are there. When I started working here, I noticed them. I think [administrator (A)-A] put them there." On June 25, 2024, at 8:47 a.m., when asked about the unattended medications, A-A stated, "I took them. It was old meds and I don't know how they got there, but I didn't feel they should be there so I took them away." The licensee's 7.11 Medication Storage policy, dated November 1, 2021, read, " When medications are managed and stored by [licensee], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	5500 81ST AVENUE NORTH BROOKLYN PARK, MN 55443

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03090	Continued From page 46 (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all six residents, staff and visitors to the 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 24, 2024, at 10:00 a.m., the surveyor observed a sign on the front door that had a picture of a video camera and indicated cameras may be in use. The licensee lacked posting and electronic monitoring notice that contained the statutory required language. On June 26, 2024, at 11:09 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "That required wording is different than what we have on there, we can get that re-worded." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35250	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03090	Continued From page 47 (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Follow-Up
Date: *07/01/24*
Time: 11:32:03
Report: 1023241133

Food and Beverage Establishment Inspection Report

Location:
First Choice Nursing And Home
5500 81st Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039006
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634930965
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 previously issued on 06/25/24 have NOT been corrected.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED RAW ANIMAL FOOD STORED OVER READY TO EAT FOODS SUCH AS RAW BEEF OVER VEGETABLES. OPERATOR MOVED MEAT TO SAFE LOCATION DURING INSPECTION.

Issued on: 06/25/24 *Comply By: 06/25/24*

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ANSI 184 DISH WASHER IN USE BUT NO IRREVERSIBLE TEMP DEVICE AVAILABLE. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN ELIMINATION.

Issued on: 06/25/24 *Comply By: 06/25/24*

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ACQUIRE AND USE TEST STRIPS FOR CHLORINE SANITIZER.

Issued on: 06/25/24 *Comply By: 06/25/24*

Type: Follow-Up
Date: *07/01/24*
Time: 11:32:03
Report: 1023241133
First Choice Nursing And Home

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST ORIGINAL CERTIFICATE. EACH LOCATION MUST HAVE A DIFFERENT CFPM.

Issued on: 06/25/24 *Comply By: 06/25/24*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH WASHER
Violation Issued: No

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

INSPECTOR VERIFIED NEW DISH MACHINE INSTALLED.

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 1023241133 of 07/01/24.

Certified Food Protection Manager: JERRY HAVON

Certification Number: 119344 Expires: 09/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
JERRY HAVON
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *06/25/24*
Time: 10:02:54
Report: 1023241131

Food and Beverage Establishment Inspection Report

Location:
First Choice Nursing And Home
5500 81st Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039006
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634930965
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED RAW ANIMAL FOOD STORED OVER READY TO EAT FOODS SUCH AS RAW BEEF OVER VEGETABLES. OPERATOR MOVED MEAT TO SAFE LOCATION DURING INSPECTION.

Comply By: 06/25/24

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

DISHES BEING USED AND NOT SANITZED BECAUSE DISH WASHER IS BROKEN. NO 3 COMPARTMENT SINK ON SITE. ALL DIRTY DISHES MUST BE WASHED/RINSED/SANITIZED.

Comply By: 06/25/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ANSI 184 DISH WASHER IN USE BUT NO IRREVERSIBLE TEMP DEVICE AVAILABLE. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN ELIMINATION.

Comply By: 06/25/24

Type: Full
Date: *06/25/24*
Time: 10:02:54
Report: 1023241131
First Choice Nursing And Home

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
ACQUIRE AND USE TEST STRIPS FOR CHLORINE SANITIZER.
Comply By: 06/25/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.
POST ORIGINAL CERTIFICATE. EACH LOCATION MUST HAVE A DIFFERENT CFPM.
Comply By: 06/25/24

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.
DISH MACHINE BROKEN. REPAIR/REPLACE DISH MACHINE. USE ALL DISPOSABLE ITEMS UNTIL FUNCTIONAL.
Comply By: 06/25/24

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH MACHINE (BROKEN)
Violation Issued: No

Chlorine: = at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

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

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

Type: Full
Date: *06/25/24*
Time: 10:02:54
Report: 1023241131
First Choice Nursing And Home

Food and Beverage Establishment Inspection Report

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

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 1023241131 of 06/25/24.

Certified Food Protection Manager: JERRY HAVON

Certification Number: 119344 Expires: 09/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
JERRY HAVON
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us