Electronically Delivered

December 6, 2024

Licensee
Caring Nest Home Health LLC
447 Marnie Street South
Maplewood, MN 55119

RE: Project Number(s) SL40106015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 24, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

Per 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 residents/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.

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 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
	40106	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NEST HOME HEALTH LLC	447 MARNIE STREET SOUTH MAPLEWOOD, MN 55119

(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 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: SL40106015-0 On October 21, 2024, through October 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one resident receiving services under the Provisional Assisted Living Facility 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 22, 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		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 2 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 interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for four of four employees (assisted living director in residency/unlicensed personnel (ALDIR/ULP)-A, ULP-B, ULP-D, and clinical nurse supervisor (CNS)-C), and TB training for one of one employee (CNS-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 660		

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0 660	Continued From page 3 The licensee's Facility TB Risk Assessment completed on October 22, 2024 (after initiation of the survey), read their TB risk level was low. ALDIR/ULP-A, ULP-B, and ULP-D ALDIR/ULP-A was hired on February 15, 2024, to oversee the operation of the facility and provide assisted living services. ULP-B was hired on March 8, 2024, to provide assisted living services. The licensee's contact list indicated ULP-D was hired as an ULP but did not provide a hire date. ALDIR/ULP-A, ULP-B, and ULP-D's employee records included a completed first step TST both read negative on February 14, 2024, March 8, 2024, and March 24, 2024, respectively. All three employee records lacked a completed second TST. CNS-C CNS-C was hired on January 29, 2024, to provide training and supervision of staff and nursing services to residents. CNS-C's employee record included a chest x-ray (CXR) competed on September 15, 2020. CNS-C's record lacked the following requirements: -documentation of a positive two-step TST or blood test or documentation of refusal of both the two-step TST and blood test followed by a new CXR and provider evaluation; and -TB training upon hire. The Minnesota Department of Health (MDH)	0 660		

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0 660	Continued From page 4 "Tuberculosis screening," last updated October 15, 2024, indicated all health care personnel required TB education baseline TB screening to include: -assessing for current symptoms of active TB disease; -assessing TB history; and -testing for the presence of Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated under health care worker (HCW) education, TB training was required at the time of hire. The licensee's Tuberculosis Screening policy effective January 15, 2024, indicated each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. The policy also indicated a two-step TST was required for baseline TB screening of health care workers who have not had a TST within the previous three (3) months of hire. If the first TST result was negative, then the 2nd TST is administered one to three weeks later. The licensee's Tuberculosis Prevention and Control policy effective January 15, 2024, indicated training and information on TB would be provided for all employees and volunteers at the time of employment and annually during infection control in-services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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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, 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 comply with the requirements of the Minnesota State Fire Code. 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	0 780		

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0 780	Continued From page 6 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on October 21, 2024, from 12:30 p.m. to 1:15 p.m., with assisted living director in residence/ unlicensed personnel (ALDIR/ ULP)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code: SMOKE ALARMS The smoke alarms were tested throughout the facility. During the test the smoke alarm in resident sleeping room 5, was not interconnected so activation of one alarm activates all alarms throughout the facility. The smoke alarms did not deliver an audible sound as designed when tested in resident sleeping room 2, and 3. During the tour there were several smoke alarms chirping indicating maintenance required. Smoke alarms are required to be maintained in accordance with manufactures installation instructions. CARBON MONOXIDE ALARMS There was not a carbon monoxide alarm installed outside and within 10 feet of the basement resident sleeping rooms. Carbon monoxide alarms are required to be installed and maintained outside and within 10 feet of all residential sleeping rooms. MARKED EXIT DOORS	0 780		

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0 780	Continued From page 7 The sliding patio door leading to the back deck was marked with an exit sign leading occupants to this door as an available exit. Marked exit doors are required to be of the side swinging type door and not a sliding door. During the facility tour ALDIR/ ULP-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day	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 Code; and This MN Requirement is not met as evidenced by: Based on observation, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 790		

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0 790	Continued From page 8 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 a facility tour on October 21, 2024, from 12:30 p.m. to 1:15 p.m., with assisted living director in residence/ unlicensed personnel (ALDIR/ ULP)-A, it was observed that the required fire extinguishers did not include documentation they were serviced annually as required. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During the facility tour ALDIR/ ULP-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 790		

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0 800	Continued From page 9	0 800		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect more than a limited number of 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On a facility tour on October 21, 2024, from 12:30 p.m. to 1:15 p.m., with assisted living director in residence/ unlicensed personnel (ALDIR/ ULP)-A, the surveyor made the following observations of facility disrepair:	0 800		

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0 800	Continued From page 10 The public basement bathroom door hinge screws on both doors were loose and the doors would not close, and latch as designed and installed at the time of construction. The toilet seat was removed in the main floor half bath near the attached garage entrance. The exhaust fan in the upstairs public bathroom was making a loud noise when turned on and required maintenance. During the facility tour ALDIR/ ULP-A, verified the above listed observations while accompanying on the tour. 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 11 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, provide documentation of 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 October 21, 2024, at 12:00 p.m., assisted living director in residence/ unlicensed personnel (ALDIR/ ULP)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety	0 810		

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0 810	Continued From page 12 and evacuation training, and evacuation drills for the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation the required training for employees was provided separate from fire drills and specific to the facility. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation training was provided for residents as required. During an interview on October 21, 2024, at 12:00 p.m., ALDIR/ ULP-A, stated documentation was not available in writing indicating employees and residents were trained based on the FSEP as required. DRILLS Record review of the available documentation 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 evident by providing documentation a drill was completed on February 23, 2024, during second shift only. During an interview on October 21, 2024, at 12:00 p.m., ALDIR/ ULP-A, stated documentation was not available indicating evacuation drills were completed as required. No further information was provided.	0 810		

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0 810	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a	0 920		

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0 920	Continued From page 14 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 October 21, 2024, at 11:40 a.m., assisted living director in residency/unlicensed personnel (ALDIR/ULP)-A provided R1's Resident Contract for Assisted Living and indicated the contract was used by the licensee for all residents who received services by licensee. R1's Resident Contract for Assisted Living signed on January 29, 2024, lacked a disclosure of the facility's ability to provide specialized diets and a description of and any limitations to the housing or assisted living services to be provided for the contracted amount. On October 21, 2024, at 3:35 p.m., ALDIR/ULP-A stated when they received this assisted living contract by a consultant, they did not look over the contract and did not know what the content requirements were. On October 22, 2024, at 12:15 p.m., R1 stated he went to the grocery store with ALDIR/ULP-A and while shopping, they got into an argument because he wanted food that contained pork products and was told he couldn't have them in the house. R1 stated he was frustrated because he couldn't have a pepperoni pizza. R1 explained he was not told about the limitations of the menu before he signed the contract.	0 920		

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0 920	Continued From page 15 On October 22, 2024, at 12:25 p.m., ALDIR/ULP-A stated when R1 moved in, he provided him the contract, Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), Bill of Rights (BOR), and emergency preparedness training and said he told R1 about the pork product limitations. ALDIR/ULP-A stated the pork product limitations and whether they could provide specialized diets were not disclosed in the assisted living contract. The licensee's Assisted Living Contracts policy effective January 15, 2024, indicated the contract must include a description of any limitations to the housing or assisted living services to be provided for the contracted amount, and a disclosure of the facility's ability to provide specialized diets. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the	0 940		

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0 940	Continued From page 16 housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 940		

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0 940	Continued From page 17 On October 21, 2024, at 11:40 a.m., assisted living director in residency/unlicensed personnel (ALDIR/ULP)-A provided R1's Resident Contract for Assisted Living signed on January 29, 2024, and indicated the contract was used by the licensee for all residents who received services by licensee. R1's contract lacked the following required content: -whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; -whether the facility has an agreement to provide housing support under section 256I.04, subd. 2, paragraph (b); and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On October 21, 2024, at 3:35 p.m., ALDIR/ULP-A stated when they received this assisted living contract by a consultant, they did not look over the contract and did not know what the content requirements were. The licensee's Assisted Living Contracts policy effective January 15, 2024, indicated the contract must include: -whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; -whether the facility has an agreement to provide housing support under section 256I.04, subd. 2, paragraph (b); and - a description of the rent requirements for people who are eligible for medical assistance waivers	0 940		

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0 940	Continued From page 18 but who are not eligible for assistance through the housing support program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document the direct	01440		

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01440	Continued From page 19 supervision of unlicensed personnel (ULP) for two of two employees (assisted living director in residency/ULP (ALDIR/ULP)-A, ULP-B) providing assisted living services. 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: ALDIR/ULP-A ALDIR/ULP-A was hired on February 15, 2024, to provide assisted living services to residents, supervision of staff, and managerial duties for the licensee. On October 21, 2024, between 10:00 a.m. and 4:00 p.m., ALDIR/ULP-A provided supervision and other services to R1 throughout the day. ULP-B ULP-B had a hire date of March 8, 2024, to provide assisted living services to licensee's residents. On October 22, 2024, at 8:35 a.m., ULP-B was observed to pass medications and assist with blood glucose monitoring to one resident. ALDIR/ULP-A and ULP-B's employee records lacked documentation of direct supervision to verify that the work was being performed competently and to identify problems and solutions to address issues related to the staff's	01440		

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01440	Continued From page 20 ability to provide the services. During a phone interview on October 23, 2024, at 9:20 a.m., clinical nurse supervisor (CNS)-C initially stated she had not performed direct supervision of tasks and said she was going to do annual retraining of the tasks. CNS-C then stated she performed direct supervision of tasks such as medication administration and blood glucose monitoring (in June 2024) with some staff but not with all staff. CNS-C stated the supervision would be documented in the licensee's online health record program (Rtasks). ALDIR/ULP-A was unable to locate any documentation of supervision being performed. The licensee's Supervision of Unlicensed Personnel policy effective January 15, 2024, indicated 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 delegated tasks for residents, and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The	01460		

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01460	Continued From page 21 orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of three employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on October 21, 2024, at 10:30 a.m., assisted living director in residency/unlicensed personnel clinical (ALDIR/ULP)-A stated the licensee was aware of required contents for an employee record. CNS-C was hired January 29, 2024, to provide training and supervision of staff and clinical services to licensee's resident. CNS-C's employee record lacked documentation to indicate CNS-C completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents.	01460		

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01460	Continued From page 22 On October 23, 2024, at 8:45 a.m., assisted living director in residency/unlicensed personnel (ALDIR/ULP)-A stated the only training CNS-C completed was documented on the 2022 training transcript which was not for this licensee. He did not have any documentation of orientation training available. During phone interview on October 23, 2024, at 9:20 a.m., CNS-C stated she did not complete any orientation training with licensee but did complete some training back in 2022 which was under a different licensee. The licensee's Facility Employee Orientation policy effective January 15, 2024, indicated all assisted living employees, including those who provide direct care, who provide supervision of direct care, or who provide management services for the facility, shall complete an orientation on topics required by Minnesota statutes and rules for assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of	01530		

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01530	Continued From page 23 employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received the required initial eight (8) hours of dementia care training for one of one employee (clinical nurse supervisor (CNS)-C)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: CNS-C was hired January 29, 2024, to provide	01530		

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01530	Continued From page 24 training and supervision of staff and clinical services to licensee's resident. On October 21, 2024, at 10:30 a.m., during entrance conference, CNS-C stated she worked at the facility approximately four (4) hours every week and at another assisted living facility unrelated to licensee. CNS-C's employee record lacked eight (8) hours of initial dementia training within 120 working hours of employment start date. On October 22, 2024, at 9:20 a.m., CNS-C stated she did not have any training completed with licensee and that she did dementia training five (5) years ago at another job and had not completed any dementia training since then. The licensee's Dementia Care Training policy effective January 15, 2024, indicated supervisors of direct-care staff must have at least eight hours of initial training within 120 working hours of employment start date of the following topics: - An explanation of Alzheimer's Disease and other dementias; - Assistance with activities of daily living (ADL's); - Problem solving with challenging behaviors; - Communication skills; and - Person-centered planning and service delivery. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED	01560		

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01560	Continued From page 25 (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. 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:	01560		

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01560	Continued From page 26 When interviewed on October 22, 2024, at 10:50 a.m., assisted living director in residency/unlicensed personnel (ALDIR/ULP)-A stated he did not have a description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered, in written or electronic form to consumers, and indicated he was not aware of this requirement. The licensee's Dementia Care Training policy effective January 15, 2024, indicated the facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01620 SS=D	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	01620		

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	40106	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NEST HOME HEALTH LLC	447 MARNIE STREET SOUTH MAPLEWOOD, MN 55119

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01620	Continued From page 27 be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a change in condition assessment for one of one resident (R1) when newly diagnosed with diabetes requiring interventions. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's progress note written by clinical nurse supervisor (CNS)-C on June 12, 2024, indicated R1 was newly diagnosed with diabetes and put on an oral hypoglycemic medication (metformin) and began blood glucose (BG) monitoring twice a day in the morning before breakfast and at bedtime. On October 22, 2024, between 8:35 a.m. and	01620		

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01620	Continued From page 28 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R1 and assist with BG check. R1's medical record lacked a full RN assessment after diagnosis of diabetes requiring new services. R1's Assessment As Of Date (90-day assessment) dated August 2, 2024, indicated under Diabetes Management that R1 was pre-diabetic and tried to watch their diet by eating less carbohydrates and sugar. RN provided education on foods to eat but the assessment did not include BG monitoring. On October 23, 2024, at 9:20 a.m., CNS-C stated she did not complete an assessment but completed a clinical note and updated R1's service plan. The licensee's Nursing Assessment and Reassessment of Residents policy effective January 15, 2024, indicated the RN would reassess the resident any time the resident returns from a hospital or nursing home stay, has a change in condition, experiences an incident such as a fall, or experiences any unusual symptoms or possible side effects from medications. At the reassessments, the RN will: -review the resident's service plan; -evaluate the resident's medication management services and the resident's medications; -evaluate the resident's treatments, if any; -communicate any new problems or concerns to the resident's physician or health care providers; and -update the service plan as necessary based on the resident's needs.	01620		

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01620	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of one resident	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 30 (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 22, 2024, between 8:35 a.m. and 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R1 and assist with blood glucose check. R1 was admitted on January 29, 2024, with diagnoses that included traumatic brain injury (TBI), prediabetes, emphysema (lung condition that causes shortness of breath), and anxiety. R1's unsigned Service Plan-Modification printed October 23, 2024, indicated R1 received assistance with bathing reminders, meal assistance, housekeeping, laundry, behavior management, meals, medication administration, vital signs, safety checks and blood glucose monitoring. R1's service plan lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. On October 23, 2024, at 9:20 a.m., clinical nurse supervisor (CNS)-C stated she updated the service plan but did not know if R1 signed it. CNS-C stated assisted living director in	01640		

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01640	Continued From page 31 residency/ULP (ALDIR/ULP)-A was also responsible for making sure the service plan was signed. The licensee's Service Plan policy effective January 29, 2024, indicated the service plan and any revisions must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the	01790		

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01790	Continued From page 32 unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	01790		

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01790	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 21, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-C stated the facility provided medication management service to the licensee's resident. R1's progress note entry dated October 3, 2024, at 4:25 p.m., assisted living director in residency/unlicensed personnel (ALDIR/ULP)-A documented R1 left the facility at 4:20 p.m., with R1's daughter and would be gone until October 5, 2024. R1's electronic medication administration record (eMAR) dated October 3, 2024, through October 6, 2024, read R1's 8:00 a.m., 5:00 p.m., and 9:00 p.m., medications were sent with R1. On October 22, 2024, at 10:45 a.m.,	01790		

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01790	Continued From page 34 ALDIR/ULP-A stated there were no written procedures available for handling medications for unplanned leave of absence for ULPs to follow but he explained he was shown by the RN on how to perform that task. On October 23, 2024, at 9:20 a.m., during phone interview, CNS-C explained what she would do if a resident needed medications for a leave of absence but later stated there were no written procedures available for ULP's to follow. The licensee's Medications For A Resident Who Will Be Away From Facility When Medications Are Scheduled policy effective January 15, 2024, noted the RN has developed written procedures for the ULP providing medications for residents having unplanned time away when the licensed nurse was not available. The procedures will address: -The type of container to be used for the medications appropriate to the facility's medication system; -how the container must be labeled; -written information about the medications to be provided; -how the ULP must document in the resident's record what medications have been provided, including the date the medications were provided and who received them, the person who is provided the medications to the resident, the number of medications provided to the resident and other required information; -how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or their designee; -a review by the RN of the completion of the task and to verify that it was done accurately by the ULP; and	01790		

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01790	Continued From page 35 -how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and dose of the returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) receiving blood glucose (BG) monitoring. 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).	01970		

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01970	Continued From page 36 The findings include: On October 22, 2024, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-B set up R1's blood glucometer (device that reads BG in blood). R1 pricked his finger, obtained a sample of blood and gave the glucometer back to ULP-B. After cleaning up, ULP-B entered the result into R1's electronic health record (RTasks). R1 was admitted on January 29, 2024, with diagnoses that included traumatic brain injury (TBI), prediabetes, emphysema (lung condition that causes shortness of breath), and anxiety. R1's resident note dated June 12, 2024, at 12:22 p.m., clinical nurse supervisor (CNS)-C indicated R1 was newly diagnosed with diabetes and was put on oral hypoglycemic (lowers BG) medication (metformin) and also began fasting (in morning before eating) and at bedtime BG checks. R1's unsigned service plan with print date of October 23, 2024, indicated R1 received assistance with behavior management, meals, BG checks, safety checks, shopping assistance, medication administration, and transportation assistance. R1's vital sign record dated September 21, 2024, through October 21, 2024, indicated R1's BG was checked two times a day at 8:00 a.m. and 10:00 p.m. R1's record lacked prescriber orders for BG checks. On October 23, 2024, at approximately 11:15 a.m., assisted living director in	01970		

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01970	Continued From page 37 residency/unlicensed personnel (ALDIR/ULP)-A stated they did not have BG monitoring provider orders, but the pharmacy told them what the order was. ALDIR/ULP-A stated he would request the order from the pharmacy. On October 23, 2024, at 3:18 p.m., the surveyor sent an email to ALDIR/ULP-A asking if they received any orders from the pharmacy. At 3:19 p.m., ALDIR/ULP-A responded by email indicating they had not received anything from the pharmacy and that the pharmacy was short staffed. On October 24, 2024, at 8:37 a.m., the surveyor emailed licensee informing them they had until 10:00 a.m. to provide the requested provider orders. On October 24, 2024, at 11:28 a.m., upon survey exit, the surveyor did not receive any requested provider orders. The licensee's Treatment and Therapy Management Plan policy effective January 15, 2024, indicated a current, written or electronically recorded prescriber's order would be obtained before treatment administration is provided to a resident. The policy also indicated the orders would be maintained in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *10/22/24*
Time: 11:30:00
Report: 1031241303

Food and Beverage Establishment Inspection Report

Location:
CARING NEST HOME HEALTH LLC
447 MARNIE STREET SOUTH
Maplewood, MN55119
Ramsey County, 62

Establishment Info:
ID #: 0043725
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

LYSOL SPRAY USED ON FOOD CONTACT SURFACES MEASURED > 400 PPM.
DISCONTINUE USING NON-APPROVED SPRAY CHEMICALS ON FOOD CONTACT SURFACES.

MAKE BLEACH AND WATER SPRAY BOTTLE, USE SANI STRIPS TO CHECK CONCENTRATION (50-200PPM).

-COS

Comply By: 10/22/24

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.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE. PROVIDE IRREVERSIBLE MEASURING AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 10/28/24

Type: Full
Date: *10/22/24*
Time: 11:30:00
Report: 1031241303
CARING NEST HOME HEALTH LLC

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.

ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)

Comply By: 10/28/24

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM). ESTABLISHMENT DOES HAVE SAFESERV OR SIMILAR POSTED.

CFPM APPLY ONLINE INFO SENT WITH REPORT.

Comply By: 10/22/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

MULTIPLE HOLES AND PEST DRIPPINGS FOUND IN CABINETS (HOLES USED FOR LED LIGHTING).

CLEAN AND SANITIZE CABINETS AND FILL ALL HOLES.

Comply By: 11/12/24

Surface and Equipment Sanitizers

Dimethyl Ethyl Benzyl Ammo: > 400 at Degrees Fahrenheit
Location: Lysol Spray
Violation Issued: Yes

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

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Type: Full
Date: *10/22/24*
Time: 11:30:00
Report: 1031241303
CARING NEST HOME HEALTH LLC

Food and Beverage Establishment Inspection Report

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

Nurse Evaluator on site: Anna Bohnen

All violations discussed with PIC during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Staff must prepare sanitizer bucket or squirt bottle daily. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has right basin designated for handwashing and the right basin for product washing/prep sink.

- When cooking food, make sure to use a thin-probe thermometer to check temperatures.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031241303 of 10/22/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Aoiub Hassan
Person in Charge

Signed:_____
Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us