DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 3, 2024

Licensee
Minn Care Home Health
3541 Flag Avenue North
New Hope, MN 55427

RE: Project Number(s) SL35572015

Dear Licensee:

On October 22, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 9, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 9, 2024 survey.

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.

At the time of this follow-up survey completed on October 22, 2024, we identified the following violation(s):

0830-Local Laws Apply-144g.45 Subd. 3

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

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
	35572	A. BUILDING: _____ B. WING _____	R 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	3541 FLAG AVENUE NORTH NEW HOPE, MN 55427

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#35572015-1 On October 22, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 9, 2024. At the time of the survey, there were 4 active residents; 4 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}		

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{0 470}	Continued From page 1 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 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: No further action required.	{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,	{0 480}		

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{0 480}	Continued From page 2 chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action required.	{0 490}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality	{0 580}		

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{0 580}	Continued From page 3 management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: No further action required.	{0 580}		
{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 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: No further action required.	{0 640}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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{0 680}	Continued From page 4 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (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: No further action required.	{0 680}		
{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	{0 790}		

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{0 790}	Continued From page 5 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: No further action required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{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;	{0 810}		

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{0 810}	Continued From page 6 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements.	0 830		

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0 830	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. By failing to obtain required permits for replacement of egress windows. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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, at 12:30 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. The surveyor confirmed that the window in resident bedroom located in the basement had been replaced and met the minimum opening requirement. On October 22, 2024, at 12:55 p.m., licensed assisted living director (LALD)-C stated the licensee did not have a recent building permit or inspection on file with the city to replace the window. LALD-C also stated the licensee is working with the contractor to obtain a permit from the city. Under MN Rules 1300.0120, An owner or authorized agent who intends to construct, enlarge, alter, repair, move, demolish, or change	0 830		

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0 830	Continued From page 8 the occupancy of a building or structure, or to erect, install, enlarge, alter, repair, remove, convert, or replace any gas, mechanical, electrical, plumbing system, or other equipment, the installation of which is regulated by the code; or cause any such work to be done, shall first make application to the building official and obtain the required permit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: No further action required.	{01960}		

Electronically Delivered

September 18, 2024

Licensee
Minn Care Home Health
3541 Flag Avenue North
New Hope, MN 55427

RE: Project Number(s) SL35572015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 9, 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 . . ."

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
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

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

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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: SL35572015-0 On August 6, 2024, through, August 9, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents receiving services under the provider's Assisted Living Facility license. An immediate correction order was issued on August 8, 2024 for tag identification 0820. The immediacy of the order was not removed prior to survey exit.	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.	
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0 470	Continued From page 1 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 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 observation, interview, and record review, the licensee failed to ensure a staffing plan was developed, potentially affecting all licensee's current 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	0 470		

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(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
0 470	Continued From page 2 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: During facility tour on August 6, 2024, at 10:30 a.m., the surveyor observed a posted staff schedule indicating which staff member was working on each shift. During interview on August 6, 2024, at 10:50 a.m., the surveyor asked registered nurse (RN)-A what her position with the licensee was. RN-A stated she was the only RN for the licensee at the time. The surveyor then asked RN-A if a staffing plan had been developed by the clinical nurse supervisor. RN-A stated she knew that administration made the schedules for staff. RN-A denied developing a staffing plan and indicated she was not aware she needed to develop a staffing plan. The licensee's January 1, 2020, Staffing Plan policy indicated the supervisor will assist the registered nurse with adequate staffing of qualified personnel that meets the resident needs according to their service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 480		

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	35572	A. BUILDING: _____ B. WING _____	08/09/2024

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0 480	Continued From page 3 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 August 6, 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		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services	0 490		

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0 490	Continued From page 4 appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs potentially affecting all licensee's current residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include:	0 490		

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0 490	Continued From page 5 During a facility wide tour on August 6, 2024, at approximately 10:30 a.m., the surveyor noted no activity calendar posted on any common wall which indicating daily activities for residents residing in the licensee's establishment. During observations on August 6, 2024, from approximately 10:30 a.m. to 2:15 p.m., the surveyor did not observe any activities offered for the licensee's residents. During interview on August 6, 2024, registered nurse (RN)-A stated the licensee did provide a daily program of activities for residents. During interview on August 6, 2024, at approximately 11:05 a.m., R1 stated that he was not aware of any calendar indicating what activities were available for residents. R1 also stated that staff did not provide any activities. During interview on August 6, 2024, at approximately 11:45 a.m., R2 stated the licensee did not provide any type of activities except for residents to go outside or watch television. The licensee's January 1, 2020, Activity Programming policy, indicated a monthly activity calendar will be created and available to all residents. Activities may include social events, religious events, exercise and wellness events, creative opportunities, intellectual opportunities, cultural events, and volunteer opportunities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		

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0 580	Continued From page 6	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. 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: During an interview on August 6, 2024, at 10:35 a.m., licensed assisted living director (LALD)-C stated the licensee conducted a weekly meeting	0 580		

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0 580	Continued From page 7 with staff to discuss any of the licensee's issues. LALD-C stated there was not a specific meeting or documentation to evaluate the quality of care by reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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 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 support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC).	0 640		

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0 640	Continued From page 8 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: During a building tour on August 6, 2024, at 10:45 a.m., the surveyor noted the facility's common areas had no posting information related to reporting suspected maltreatment to MAARC. During an interview on August 6, 2024, at 11:05 a.m., licensed assisted living director (LALD)-C verified the required information was not posted in the common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 9 (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 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). The findings include: The licensee's undated EPP lacked evidence of the following required content:	0 680		

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0 680	Continued From page 10 - annual review of the EPP; - quarterly review of missing resident policy; - EPP related to patient population; - process for emergency preparedness (EP) collaboration; - subsistence needs for staff and residents; - policies and procedures for sheltering in place; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under wavier declared by secretary; - emergency officials contact information; - methods for sharing information; - long term care family notifications; and - emergency prep testing to include a disaster drill. On August 6, 2024, at 12:10 p.m., licensed assisted living director (LALD)-D stated the documents provided to surveyor were the complete emergency disaster preparedness plan. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have a plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan would be reviewed and updated at least annually. In addition, a disaster drill would be documented and conducted at the residence at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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0 790	Continued From page 11 (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 and interview, the licensee failed to maintain the portable fire extinguishers. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 07, 2024, from approximately 11:05 a.m. to 11:45 a.m., survey staff toured the facility with unlicensed personnel (ULP)-E and observed that the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that annual inspections had been performed as required. Annual inspections of the fire extinguishers are required to ensure that all	0 790		

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0 790	Continued From page 12 systems are maintained and remain in working order. ULP-E verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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	0 800		

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0 800	Continued From page 13 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 07, 2024, from approximately 11:05 a.m. to 11:45 a.m., survey staff toured the facility with unlicensed personnel (ULP)-E. The following was observed. GENERAL MAINTENANCE: Basement bathroom was missing paint on the wall behind the toilet and vanity top was missing a tile. The carpet was heavily stained on the steps going to the basement and in the resident room. The basement had a musty odor throughout. Scratches on the main floor hallway wall. The door going to the basement had scratches on it. Residents room doors on the main floor had scratches and holes in them. Outdoor deck was deteriorating and had its finish coming off. ULP-E stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to 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	0 810		

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0 810	Continued From page 15 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 August 08, 2024, at approximately 11:30 a.m., with licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility via email. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide 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 included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but 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	0 810		

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0 810	Continued From page 16 construction type. Emergency evacuation map did not show location and number of resident rooms on the main floor and did not have an evacuation map to show the basement layout. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drills", undated, indicated evacuation drills were conducted on April 26, 2024, and October 25, 2023. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. No other documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must	0 820		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	3541 FLAG AVENUE NORTH NEW HOPE, MN 55427

(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
0 820	Continued From page 17 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 resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 07, 2024, from approximately 10:45 a.m. to 11:30 a.m., survey staff toured the facility with unlicensed personnel (ULP)-E. During the tour, survey staff asked ULP-E to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom in the basement: Window measured 22	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35572	A. BUILDING: _____ B. WING _____	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	3541 FLAG AVENUE NORTH NEW HOPE, MN 55427

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0 820	Continued From page 18 inches clear width, 22 inches clear height, and 484 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to ULP-E that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was not removed prior to survey exit.	0 820		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35572	A. BUILDING: _____ B. WING _____	08/09/2024

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01960	Continued From page 19 administration 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 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 a tour of licensee's establishment on August 6, 2024, at 10:00 a.m., licensed assisted living director (LALD)-C stated ULP-B was in R1's room completing a treatment to R1's coccyx wound. R1 was admitted to the licensee on April 19, 2023, with diagnoses of a pressure ulcer of the sacral region, stage 4, type II diabetes with diabetic peripheral angiopathy without gangrene, essential hypertension, and disorder of the kidney/ureter. R1's service plan dated April 19, 2023, indicated R1 was receiving the following services: bathing assistance, catheter care, behavior management, dressing, and grooming assistance. R1's provider orders for coccyx treatment dated July 15, 2024, indicated: -staff are to wash your hands with soap and water before beginning the dressing change and prepare a clean surface for dressings. - Cleanse coccyx wound with mild unscented soap (such as Cetaphil, Cerave or Dove) and water	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35572	A. BUILDING: _____ B. WING _____	08/09/2024

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01960	Continued From page 20 - Apply small amount of VAS HE on gauze, lay into wound bed, let sit for 10 minutes, remove gauze (do not rinse) - Primary dressing: Gently fill cavity with Alginate ensuring to fill any tunnels or undermined areas (do not over pack). - Secondary dressing: Cover with ABD pad and secure with medipore tape -Change daily and as needed for soilage and/or saturation. R1's record lacked documentation of R1's prescribed treatment to the coccyx wound or that completion of R1's treatment to the coccyx was completed. During interview on August 6, 2024, at 10:25 a.m., registered nurse (RN)-A stated the licensee completed the above wound care on days that the home care agency does not come to do the prescribed treatment to R1's coccyx wound. RN-A stated ULP-B has been trained by the home care agency to complete the coccyx wound treatment and RN-A verified ULP-B demonstrated competency completing the above wound treatment to R1's coccyx. RN-A stated the licensee completed R1's treatment to the coccyx every other day during the morning shift. RN-A stated she assessed R1's wound the week prior and measured the area on R1's coccyx. RN-A stated she could not find a place in the electronic medical record to document the results of the wound measurement. On August 6, 2024, at 12:45 p.m., surveyor asked LALD-C to provide documentation of R1's prescribed treatment to the coccyx wound or completion of R1's treatment to the coccyx showing this was completed. Surveyor asked LALD-C multiple times to provide documentation.	01960		

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01960	Continued From page 21 There was no documentation provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

DEPARTMENT OF HEALTH

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

Type: Full
Date: *08/06/24*
Time: 11:00:00
Report: 1031241195

Food and Beverage Establishment Inspection Report

Location:
Minn Care Home Health
3541 Flag Avenue North
New Hope, MN55427
Hennepin County, 27

Establishment Info:
ID #: 0039117
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632006270
ID #:

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

The following orders were issued during this inspection.

4-300 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: 08/09/24

Surface and Equipment Sanitizers

Dimethyl Ethyl Benzyl Ammo: = 200 at Degrees Fahrenheit
Location: Lysol NSF Cleaner
Violation Issued: No

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Deli Turkey
Temperature: 37 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

Nurse Evaluator on site: Elyse Jones

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.

- Always thaw in 1 of the following ways:
1. With item in a bowl of water in sink with water stream running into the bowl.
2. In refrigerator (place on plate of in bowl).
3. In microwave.

- Staff uses a Lysol NSF approved sanitizer for cleaning.

- 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.

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

- When preparing 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 1031241195 of 08/06/24.

Certified Food Protection Manager: Ikenna C. Dijeh

Certification Number: FM107375 Expires: 07/28/27

Inspection report reviewed with person in charge and emailed.

Signed:_____

Ike Dijeh
Person in Charge

Signed:_____

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