Electronically Delivered

January 10, 2025

Licensee
Topcare Health Services LLC
8936 Douglas Drive North
Brooklyn Park, MN 55445

RE: Project Number(s) SL35134015

Dear Licensee:

On December 16, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 18, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 17, 2024

Licensee
Topcare Health Services LLC
8936 Douglas Drive North
Brooklyn Park, MN 55445

RE: Project Number(s) SL35134015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35134	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPCARE HEALTH SERVICES LLC	8936 DOUGLAS DRIVE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35134015-0 On September 16, 2024, through September 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five (5) residents; 5 receiving services under the Assisted Living license. An immediate order was issued for tag identification 1290 on September 17, 2024. During the survey, the licensee took action to address the violation. Noncompliance remained at a scope and level of I. An immediate order was issued for tag identification 0820 on September 18, 2024. During the survey, the licensee took action to address the violation. Noncompliance remained at a scope and level of G.	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	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required 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 and interview, the licensee failed to ensure the staffing plan was evaluated twice per year as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 17, 2024, at approximately 2:00 p.m., the surveyor requested and received the licensee's staffing plan. The licensee's undated Facility Staffing Plan lacked a twice-yearly evaluation of the appropriateness of staffing levels in the facility. On September 17, 2024, at approximately 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware of the requirement to review the staffing plan twice per year. The licensee's Staffing policy dated August 1, 2021, indicated the staffing plan would be evaluated as part of the Quality Management program at least twice per year. 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 following services to residents:	0 480		

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0 480	Continued From page 3 (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 September 17, 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		
0 640 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:	0 640		

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0 640	Continued From page 4 (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 post the required information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and by telephones. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On September 16, 2024, at approximately 11:00 a.m., during a facility tour, the facility entry and common areas were observed to lack the required posting of the information and reporting number for MAARC and the required posting of the 911 emergency number near the facility telephone in the common area.	0 640		

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0 640	Continued From page 5 On September 16, 2024, at approximately 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware of the requirements to post MAARC reporting information and 911 emergency numbers. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated contact information for the MAARC would be posted in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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	0 780		

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0 780	Continued From page 6 operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate and failed to keep the facility in compliance with the Minnesota Fire Code. These deficient conditions had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility tour with the owner/manager (O/M)-I on September 17, 2024, between 9:00 a.m. and 10:30 a.m. the following deficient conditions were observed: SEPARATION: The surveyor observed that the door between the home and the garage had a window in it.	0 780		

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0 780	Continued From page 7 The surveyor explained to the O/M-I that the wall between the garage and the home shall be fire rated. The door shall be fire rated as well. ELECTRICAL: The surveyor observed the receptacle cover above the lower-level bathroom sink was cracked and open to the inside of the box and that the cover for the receptacle in the mechanical room was missing. The surveyor explained to the O/M-I that all electrical boxes shall have covers on them. SMOKE ALARMS: The surveyor observed that the smoke alarms in the home were not interconnected, also the one in the upper level was over 10 years old from date of manufacture. The surveyor explained to the O/M-I that all the smoke alarms in the home shall be interconnected and any that are over 10 years old from the date of manufacture shall be replaced with like type alarms. These deficient conditions were visually verified by the O/M-I accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800		

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0 800	Continued From page 8 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 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On facility tour with the owner/manager (O/M)-I on September 17, 2024, between 9:00 a.m. and 10:30 a.m. the following deficient conditions were observed: The surveyor observed holes in the front entryway and lower-level bathroom and stained ceiling tiles that appeared wet in the lower-level outside the bathroom and in resident room 4. The surveyor explained to the O/M-I that the facility shall be kept in good repair.	0 800		

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0 800	Continued From page 9 The deficient conditions were visually verified by the O/M-I accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to 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	0 810		

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0 810	Continued From page 10 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 the required fire drills during each shift and the annual training on the fire safety and evacuation plan was not being completed for residents and documented semi-annually for employees. 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: A record review and interview were conducted on September 17, 2024, at approximately 10:00 a.m. with the owner/manager (O/M)-I on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility. FIRE/EVACUATION DRILLS: During record review the O/M-I stated the fire/evacuation drills were being completed but the record review showed they were completed with everyone present.	0 810		

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0 810	Continued From page 11 The surveyor explained to the O/M-I that the fire drills shall be completed when only the number of staff is present for that particular shift and this shall be documented. TRAINING: During record review the O/M-I stated the training had not been completed and documented for the residents and the record review showed the employees semi-annual training was not being documented. The surveyor explained to O/M-I the employees shall be trained specifically on their fire safety and emergency plan at new hire and twice a year thereafter. Also, the residents shall be offered the training once a year. Both shall be documented. The fire safety and evacuation plan shall continue to be updated annually and available within the facility. The fire drills shall be completed twice per year on each shift, at least once every other month and this shall be documented with date, time and signatures of who participated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=G	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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0 820	Continued From page 12 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 provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. 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). Findings include: On a facility tour on September 17, 2024, at 9:30 a.m. with owner/manager (O/M-I) the surveyor observed that compliant emergency escape and rescue openings were not provided in resident sleeping room 5. Occupied Resident Room Resident sleeping room 5 emergency escape and rescue clear window opening measurements are 18 inches wide, 36 inches in height and 42 inches off the floor. This bedroom is on the lower level of the facility. The windows do not meet the 20 inches minimum width requirements. The	0 820		

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0 820	Continued From page 13 windows were measured with the O/M-I, and the surveyor present. It was explained to O/M-I that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. These deficient conditions were visually verified by O/M-I accompanying on the tour. Surveyor explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate During the survey, the licensee took action to address the violation. Noncompliance remained at a scope and level of G.	0 820		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900		

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0 900	Continued From page 14 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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:	0 900		

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0 900	Continued From page 15 R1 was admitted January 18, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's Service Plan signed January 8, 2024, indicated R1's services included medication administration, meal preparation, and behavior management. R1's record included a Residential Lease authenticated by R1 on January 8, 2019. R1's record lacked an Assisted Living contract prior to assisted living services initiating on August 1, 2021. On September 17, 2024, at approximately 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged R1's record contained a residential lease. LALD/CNS-A stated they thought R1 had signed an updated contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is	0 970		

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0 970	Continued From page 16 required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of two residents (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 was admitted on June 9, 2023, and began receiving assisted living services. R2's Service Plan signed June 9, 2024, indicated R2's services included meal preparation, medication administration, and behavior management. R2's [licensee] Assisted Living Contract signed June 9, 2023, read under Miscellaneous Provisions 1. Insurance Liability and Release (p. 14), read " ...The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ... unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or	0 970		

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0 970	Continued From page 17 agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident ... unless caused by the negligence of [licensee] or its employees or agents." R2's [licensee] Assisted Living Contract signed June 9, 2023, under Indemnification section (p. 16), read "[licensee] shall not be liable for any damage or injury to the resident ... or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by the negligence or [licensee]." On September 17, 2024, at approximately 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A confirmed the contract was used for all resdients and they were unaware the contract included a waiver of liability for the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be	01290		

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01290	Continued From page 18 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for two of two employees (unlicensed personnel (ULP)-D, ULP-F). In addition, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) number for two of two employees (ULP-G, ULP-H). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: BACKGROUND STUDY CLEARANCE ULP-D ULP-D was hired on April 23, 2021, under the licensee's former comprehensive license and	01290		

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01290	Continued From page 19 began providing assisted living services on August 1, 2021. A NETStudy 2.0 Person Summary run September 16, 2024, at 1:26 p.m., indicated ULP-D had an expired COVID background study from May 7, 2021, that was affiliated with another facility owned by the licensee. ULP-D's COVID background study expired on December 31, 2022. ULP-D's schedule for July 2024, indicated ULP-D had worked on July 10, 2024, from 8:00 pm to 8:00 am on July 11, 2024. ULP-F ULP-F was hired on February 2, 2024, and began providing assisted living services. A NETStudy 2.0 Person Summary run on September 16, 2024, at 1:17 p.m., indicated ULP-F lacked a cleared background study with licensee. ULP-F's schedule for August and September 2024, indicated ULP-F had worked on August 17, 18, and 31, 2024, and September 1, 14, and 15, 2024, from 8:00 a.m., through 8:00 p.m. BACKGROUND AFFILIATION ULP-G ULP-G was hired on October 31, 2029, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. A NETStudy 2.0 Person Summary run on August 16, 2021, at 1:29 p.m., indicated ULP-G was affiliated to another facility owned by the licensee	01290		

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01290	Continued From page 20 was affiliated with the licensee on September 16, 2024 (after initiation of the survey process). ULP-G's schedule for September 2024, indicated ULP-G had worked September 8, 2024, from 8:00 a.m., through 8:00 p.m. ULP-H ULP-H was hired on May 13, 2019, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. A NETStudy 2.0 Person Summary run on August 16, 2024, at 1:23 p.m., indicated ULP-H was affiliated to another facility owned by licensee. ULP-H's schedule for August and September 2024, indicated ULP-H had worked on August 1, 6, 16, 16, 28, 29, and 30, 2024, and September 2, 3, 11, 12, 16, and 17, 2024 during the 8:00 p.m., through 8:00 a.m. shifts. On September 16, 2024, at approximately 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated that only one unlicensed personnel (ULP) was scheduled on weekends and during the night shift through the week. LALD/CNS-A acknowledged ULP-D, ULP-F, ULP-G, and ULP-H had worked shifts without continuous supervision. The NETStudy 2.0 System User Manual updated November 30, 2022, defined Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services -	01290		

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01290	Continued From page 21 Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. The manual further defined Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. The Department of Health Services (DHS) Emergency Background Studies End publication updated July 31, 2024, read "Emergency studies are no longer valid. Individuals who only have an emergency study must have a fully compliant, fingerprint-based background study." The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated the employment process included a background study using NETStudy 2.0 or current version. No further information provided. TIME PERIOD FOR CORRECTION: Immediate During the survey, the licensee took action to address the violation. Noncompliance remained at a scope and level of I.	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 22 (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 ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel ((ULP)-B). 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	01440		

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01440	Continued From page 23 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on March 12, 2024, and began providing assisted living services. On September 17, 2024, at approximately 1:30 p.m., ULP-B was observed administering medications to R2. ULP-B's record included a Home Health Supervision form and a Home Health Aide Supervision: Medication Management form, both dated and authenticated by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on March 8, 2024 (before ULP-B's hire date). ULP-B's record lacked documentation of direct supervision of ULP-B performing delegated tasks within 30 calendar days after the date on which ULP-B began working. On September 17, 2024, at approximately 2:30 p.m., LALD/CNS-A stated the Home Health Supervision and Home Health Aide Supervision: Medication Management forms in ULP-B's record dated March 8, 2024, were used to document orientation competencies. LALD/CNS-A stated ULP-B's record lacked documentation of supervision of delegated tasks within 30 days of hire. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, read "direct supervision of home health aides performing delegated tasks would be provided within 30 days	01440		

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01440	Continued From page 24 after the individual begins working for the assisted living provider and thereafter as needed based on performance." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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01470	Continued From page 25 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (unlicensed personnel (ULP)-B, ULP-H). 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	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35134	A. BUILDING: _____ B. WING _____	09/18/2024

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01470	Continued From page 26 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-B ULP-B was hired on March 12, 2024, and began providing assisted living services. ULP-B's employee record lacked documentation of the following required orientation content: -an overview of Assisted Living statutes; -an introduction and review of provider's policies and procedures related to the provision of assisted living services by the individual staff person; - compliance and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -handling of resident complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of the Ombudsman for Long-Term Care, Office of the Ombudsman of Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -review of the types of assisted living services the employee will be providing and the facility's category of licensure; -the principles of person-centered planning and service delivery and how they apply to direct	01470		

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01470	Continued From page 27 support services provided by the staff person; and -orientation to each specific resident and services provided. ULP-H ULP-H was hired on May 13, 2019, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP-H's employee record lacked documentation of the following required orientation content: -overview of assisted living statutes; -an introduction and review of provider's policies and procedures related to the provision of assisted living services by the individual staff person; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of resident complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of the Ombudsman for Long-Term Care, Office of the Ombudsman of Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -orientation to each specific resident and services provided. On September 17, 2021, at approximately 2:30 p.m., licensed assisted living director/clinical	01470		

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01470	Continued From page 28 nurse supervisor (LALD/CNS)-A stated they were unaware that orientation content was incomplete as it was automatically assigned by EduCare (online education company). The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated orientation topics would include, but not be limited, to the following: -overview of Minnesota Assisted Living Statutes 144G and Minnesota Rules Chapter 4659; -introduction to and review of the organization's policies and procedures related to the provision of assisted living services; -compliance with Minnesota's Vulnerable Adult (sections 626.556 and 5572), including requirements based on organizational policy; -the Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights; -principles of person-centered planning and service delivery and how they apply to direct support services provided by staff; -grievance policy and process, including reports to the Office of Health Facility Complaints; -consumer advocacy services; and -the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of services and the organization's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530		

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01530	Continued From page 29 (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 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 the required hours of dementia care training was received by two of two employees (unlicensed personnel (ULP)-B, ULP-H). Additionally, the licensee failed to ensure that one of two employees (ULP-H) had completed at least two (2) hours of training on topics related to dementia care for each twelve (12) months of employment thereafter. This practice resulted in a level two violation (a	01530		

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01530	Continued From page 30 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 the residents). The findings include: ULP-B was hired on March 12, 2024, and began providing assisted living services. ULP-B's employee record included a My Transcript dated September 16, 2024, indicating ULP-B received four and one quarter (4.25) hours of dementia care training during orientation instead of the required eight (8) hours. ULP-H ULP-H was hired on May 13, 2019, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP-H's employee record included a My Transcript dated December 18, 2023, indicating ULP-H received two and one half (2.5) hours of dementia care training in March 2021, zero (0) hours of dementia care training in 2022, and two and 2.5 hours of dementia care training in November 2023. ULP-H's record lacked documentation of 8 hours of dementia care training in 2021 and lacked two hours of dementia care training for each 12 months of employment thereafter. On September 17, 2024, at approximately 2:30	01530		

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01530	Continued From page 31 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware of the initial 8-hour requirement of dementia care training. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees would complete at least 8 hours of initial education within 160 working hours of employment start date in the following topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors -communication skills -person-centered planning and service delivery. The licensee's Dementia Education policy dated August 1, 2021, also indicated direct care employees would complete at least 2 hours of education on topics related to dementia for each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 32 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool and failed to ensure comprehensive nursing assessments were completed within the required 90-day timeframe for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represents a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01620		

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01620	Continued From page 33 R1 R1 was admitted on January 18, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's Service Plan dated January 8, 2024, indicated R1's services included meal preparation, medication management, and behavioral management. R1's record included Nurse Reassessment Visit forms dated August 15, 2024, May 15, 2024, February 15, 2024, and November 15, 2023. The Nurse Reassessment Visit forms consisted of a two-page assessment form lacking portions of the required content identified on the uniform assessment tool. The Nurse Reassessment Visit forms indicated specific physical assessments to be completed and marked with a checkmark next to, "NC," which is an abbreviation for, "No Change." The assessments failed to be developed and address the required content per Minnesota Administrative Rule 4659.0150. R1's Nurse Reassessment Visits were completed on November 15, 2023, February 15, 2024, May 15, 2024, and August 15, 2024, indicating 92 days had passed between each assessment. R1's comprehensive 90-day assessments were not completed within the required 90-day timeframe. R2 R2 was admitted on June 9, 2023, and began receiving assisted living services. R2's Service Plan dated June 9, 2024, indicated R2 received services for meal preparation, medication administration, and behavior	01620		

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01620	Continued From page 34 management. R2's record included Nurse Reassessment Visit forms dated December 23, 2023, March 23, 2024, June 6, 2024, and September 6, 2024. The Nurse Reassessment Visit forms consisted of a two-page assessment form lacking portions of the required content identified on the uniform assessment tool. The Nurse Reassessment Visit forms indicated specific physical assessments to be completed and marked with a checkmark next to, "NC," which is an abbreviation for, "No Change." The assessments failed to be developed and address the required content per Minnesota Administrative Rule 4659.0150. R2's Nurse Visit Reassessments completed on December 23, 2023, and March 23, 2024, indicated 91 days had passed between assessments. R2's Nurse Visit Reassessments completed on June 6, 2024, and September 6, 2024, indicated 92 days had passed between assessments. R2's comprehensive 90-day assessments were not completed within the required 90-day timeframe. On September 17, 2024, at approximately 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware the assessments had been completed greater than 90 days apart. LALD/CNS-A stated she thought that weekend days were not included in the 90 days. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, referenced Minnesota Administrative Rules 4659.0150, listing the required content to be included in the comprehensive nursing assessment.	01620		

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01620	Continued From page 35 The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments would be conducted by a RN and would not exceed 90 days from the last date of assessment. The Minnesota Administrative Rule 4659.0150, subpart B dated August 11, 2021, indicated the required content of the uniform assessment tool. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;	01730		

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01730	Continued From page 36 (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01730		

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01730	Continued From page 37 R1 R1 was admitted on January 18, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's Service Plan signed January 8, 2024, indicated R1's services included meal preparation, medication administration, and behavior management. R1's record contained a Medication Management Services Plan dated January 7, 2021, lacking the following required content: -a statement documenting the medication management services that will be provided; -a description of the storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -procedures for staff to notify a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R1's record lacked a current medication management plan to include all required content. R2 R2 was admitted on June 9, 2023, and began receiving assisted living services. R2's Service Plan signed June 9, 2023, indicated R2's services included meal preparation,	01730		

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01730	Continued From page 38 medication administration, and behavioral management. R2's record included a Medication Management Plan as part of R2's contract signed on June 9, 2023. The Medication Management Plan lacked the following required content: -a statement documenting the medication management services that will be provided; -a description of the storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R2's record lacked a current medication management plan to include all required content. On September 17, 2024, at approximately 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware of the contents required in the medication management plan and that it needed to be updated at least annually and with medication changes. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated Medication Management Plans would be kept current and updated with any changes and would include the following content: = a statement describing the medication management services to be provided; -a description of the storage of medications based on the resident assessment and	01730		

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01730	Continued From page 39 addressing resident preference, risk of diversion and instructions per manufacturer; -plans for staff notifying the licensed health professional when/if a problem with medication management services arises; and -any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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

Type: Full
Date: *09/17/24*
Time: 10:33:09
Report: 1023241209

Food and Beverage Establishment Inspection Report

Location:
Top Care Health Services
8936 Douglas Drive N
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0042190
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

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.

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

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

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

OBSERVED RAW SHELL EGGS STORED OVER LETTUCE. OPERATOR MOVED EGGS TO SAFE LOCATION DURING INSPECTION.

Comply By: 09/17/24

2-500 Responding to contamination events

2-501.11 ***** Priority 2 *****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

OPERATOR DID NOT HAVE PLAN NOR BLEACH FOR CLEANUP. SENT SAMPLE PLAN INCLUDING REQUIRED BLEACH MIXTURE TO OPERATOR TO FOLLOW.

Comply By: 09/17/24

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.

HIGH TEMP DISH WASHER IN USE BUT NO WAY OF VERIFYING INTERNAL TEMPERATURE. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN DESTRUCTION.

Comply By: 09/17/24

2-100 Supervision

2-102.12AMN

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

OPERATOR STATED CFPM COVERS FOUR LOCATIONS. CFPM CAN ONLY COVER UP TO TWO LOCATIONS NO MORE THAN 60 MILES APART IF THEY HAVE LESS THAN 10 RESIDENTS AT EACH.

Comply By: 09/17/24

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OPERATOR STATED WOOD CUTTING BOARD USED. INSTRUCTED STAFF TO DISCARD WOOD BOARD AND REPLACE WITH APPROVED MATERIAL.

Comply By: 09/17/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HAND WASH SIGN AT HAND SINK. SENT SAMPLE SIGN WITH REPORT.

Comply By: 09/17/24

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Cold Hold/ORANGE JUICE
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER #1
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER #2
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

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

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

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023241209 of 09/17/24.

Certified Food Protection Manager: ONYEKA OSAKWE

Certification Number: 40774 Expires: 07/27/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

ONYEKA OSAKWE
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
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