Electronically Delivered

April 26, 2023

Licensee
Cozy Baraka Home Care Inc
3554 Boone Avenue North
New Hope, MN 55427

RE: Project Number(s) SL36907015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 5, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36907	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COZY BARAKA HOME CARE INC	3554 BOONE 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(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: SL36907015-0 On April 4, 2023, through April 5, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements	0 490		

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0 490	Continued From page 1 (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: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all the residents of the licensee. 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	0 490		

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0 490	Continued From page 2 a large portion or all of the residents). The findings include: On March 4, 2023, at 10:00 a.m., during the entrance conference, the surveyor requested to see the licensee's daily program of social and recreational activities. On March 4, 2023, at 11:15 a.m., the surveyor did not observe any activities were planned or offered to the residents. One resident remained in his room the entire day, and the other resident laid on the couch, paced back and forth to the kitchen, outside to smoke, and to his room. On March 5, 2023, at 9:00 a.m., the surveyor did not observe any activities were planned or offered to the residents. One resident remained in his room the entire day, and the other resident sat or laid on the couch, paced back and forth to the kitchen, outside to smoke, and to his room. On March 5, 2023, at 11:37 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated the licensee had tried to set up activities and a calendar of activities, but the residents did not like to participate in planned activities and kept themselves busy with watching TV and going out in the community for walks or on a motorized wheelchair. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 650 SS=D	144G.42 Subd. 8 Employee records	0 650		

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0 650	Continued From page 3 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented a competency for the delegation of medication administration for one of one employee (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) 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	0 650		

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0 650	Continued From page 4 only occasionally). The findings include: ULP-B started work at the licensee's facility on September 21, 2022. ULP-B's employee record included a Knowledge Assessment Medication Administration - Overview completed on October 23, 2022. R1's Medication Administration Summary for January 2023, indicated ULP-B administered medications to R1 on various dates throughout the month of January. On April 5, 2023, registered nurse/licensed assisted living director (RN/LALD)-A stated ULP-B was trained, and a competency was completed by a RN. RN/LALD-A also stated that licensee had called Rtask (charting software) to inquire how to include the documentation of medication administration competency as the software was not giving them the option. Licensee's Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated licensee will "instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 680	Continued From page 5	0 680		
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; (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 maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. 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	0 680		

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0 680	Continued From page 6 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 EP plan lacked the following content: - Establishment of the Emergency Program (EP); - Develop and Maintain EP Program; - Maintain and Annual EP Updates; - Process for EP Collaboration; - Development of EP Policies and Procedures; - Subsistence Needs for Staff and Patients; - Procedures for Tracking of Staff and Patients; - Policies and Procedures Including Evacuation; - Policies and Procedures for Sheltering; - Policies and Procedures for Medical Documents; - Policies and Procedures for Volunteers; - Arrangement with Other Facilities; - Roles under a Waiver Declared by Secretary; - Development of Communication Plan; - Names and Contact Information; - Emergency Officials Contact Information; - Primary/Alternate Means for Communication; - Methods for Sharing Information; - LTC Family Notifications; - Emergency Prep Training and Testing; - Emergency Prep Training Program; - Emergency Prep Testing Requirements; - LTC Emergency Power (Typically ENGININEERING); and - Integrated Health Systems; On April 5, 2023, at 1:15 p.m., registered	0 680		

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0 680	Continued From page 7 nurse/licensed assisted living director (RN/LALD)-A stated the licensee's EP plan was missing required information. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "it is the intent that [licensee] to have in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." 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 (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:	0 790		

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0 790	Continued From page 8 Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN Statute. This had the potential to affect all 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 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 April 4, 2023, at approximately 1:00 p.m., survey staff toured the facility with the Assisted Living Director (LALD)-A. It was observed that the fire extinguisher did not have a service tag showing that it had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. This deficient condition was verified by LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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;	0 810		

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0 810	Continued From page 9 (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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 10 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: An interview and record review were conducted on April 4, 2023, at approximately 1:00 p.m., survey staff toured the facility with the Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During interview, LALD-A stated that the licensee provided annual training to employees, but not twice per year after initial hire on the fire safety and evacuation plan, as required by statute. No additional training records were provided. Record review also indicated that evacuation drills for employees had not been performed every other month as required. During interview, LALD-A stated that evacuation drills had not been performed for the employees at the time of survey. A policy was requested on evacuation drills, but one was not provided.	0 810		

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0 810	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This had the potential to affect all residents living in the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	0 910		

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0 910	Continued From page 12 R1's record included a signed Resident Agreement dated March 25, 2023. R1's Resident Agreement lacked documentation of the Health Facility Identification (HFID) number of the facility in a conspicuous place and manner. On March 5, 2023, at 2:30 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated she thought the HFID number was on resident agreement and will update the contract to meet statute requirement. The licensee's Assisted Living License Resource Manual policy for signing an assisted living contract dated 8/01/2021, states legal name and license number of the building are required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including:	01370		

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	36907	A. BUILDING: _____ B. WING _____	04/05/2023

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01370	Continued From page 13 (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required content for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	01370		

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01370	Continued From page 14 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B started employment with the licensee September 21, 2022. ULP-C started employment with the licensee June 27, 2022. ULP-B and ULP-C's employee records lacked evidence ULP-B and ULP-C received the following training: - documentation requirements for all services provided; and - reports of changes in the resident's condition to the supervisor designated by the facility. On April 5, 2023, at 12:30 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated she thought all the required training had been assigned and completed. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all ULPs would include the missing content above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	01380		

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01380	Continued From page 15 competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required content for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B started employment with the licensee September 21, 2022. ULP-C started employment with the licensee	01380		

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01380	Continued From page 16 June 27, 2022. ULP-B and ULP-C's employee records lacked evidence ULP-B and ULP-C received the following training and competency: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - administering medications or treatments as required. On April 5, 2023, at 12:30 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated she thought all the required training had been assigned and completed. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all ULPs would include the missing content above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being	01440		

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01440	Continued From page 17 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 interview and record review, the licensee failed to ensure the registered nurse (RN) provided direct supervision of staff performing delegated tasks within 30 calendar days after the task was delegated for two of two unlicensed personnel ((ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B started employment with the licensee	01440		

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01440	Continued From page 18 September 21, 2022. R1's Medication Administration Summary for January 2023, indicated ULP-B administered medications to R1 on various dates throughout the month of January. ULP-C started employment with the licensee June 27, 2022. ULP-B and ULP-C's employee record lacked direct supervision performing delegated tasks within 30 calendar days after the date on which the ULP-B and ULP-C first performed delegated tasks for residents and thereafter as needed based on performance. On April 4, 2023, at 11:20 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated ULP-B and ULP-C's record lacked documentation of supervision by the RN within 30 calendar days from the date of first performing a delegated task and thereafter as needed based on performance. RN/LALD-A stated the 30-day supervisions would not be available in any ULPs records as the licensee was not aware of the requirement. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated "direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee], and first performs the delegated tasks for residents and thereafter as needed based on performance". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	01440		

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01440	Continued From page 19 (21) days	01440		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of 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 direct-care staff completed the required amount of dementia care training in the required time frame for one of one employee (unlicensed personnel (ULP)-B).	01530		

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01530	Continued From page 20 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: The licensee held an Assisted Living Facility license effective May 5, 2022, through April 30, 2023. ULP-B started employment with licensee August 21, 2022. ULP-B's transcript indicated ULP-B completed the following dementia related online courses: - Dementia - activities - a balance approach - 0.75 hours - Dementia Communication overview - 1 hour; - Dementia problem solving - 0.75 hours; - Dementia 4 behaviors verses symptoms - 1 hour; - Dementia 5 - the journey - 0.75 hours; ULP-B's employee record included a total of 4.25 hours for dementia training. The record lacked at least eight (8) hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. On April 5, 2023, at 11:52 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated ULP-B's employee record was missing at least eight hours of initial training on topics specified under paragraph (b) within	01530		

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01530	Continued From page 21 160 working hours of the employment start date. RN/LALD-A in addition stated licensee thought the required number of hours was four, hence none of the licensee's employees will have the required eight (8) hours of dementia training. The licensee's Dementia Training policy dated August 1, 2021, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained 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	01820		

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01820	Continued From page 22 situation has occurred only occasionally). The findings include: R1 was admitted for assisted living services October 27, 2021. R1's diagnoses included chronic obstructive pulmonary disease (COPD) (a type of progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), seizure disorder, morbid obesity, and anxiety. R1's Service Plan (Wavier)- Addendum to Contract dated March 30, 2023, indicated R1 received assistance with medication administration, non-medical transportation, housekeeping, laundry, and oxygen delivery. LISINOPRIL R1's signed provider orders dated January 20, 2023, indicated Lisinopril 5 mg take one tablet by mouth once daily for high blood pressure. R1's Nursing notes dated January 20, 2023, indicated R1's Lisinopril was decreased from 10 mg to 5 mg and continue to monitor blood pressure. R1's unsigned after visit summary dated February 17, 2023, indicated R1 received Lisinopril 2.5 mg by mouth daily, indicated for high blood pressure. R1's Nursing notes dated February 24, 2023, indicated R1's Lisinopril was decreased to 2.5 mg and continue to monitor blood pressure. R1's Medication Administration Summary dated March 2023, indicated R1 was receiving Lisinopril	01820		

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01820	Continued From page 23 2.5 milligram (mg) take one tablet by mouth once daily. On April 5, 2023, at 11:26 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated prescriptions for medications are obtained from pharmacy but had not received the current orders for Lisinopril. In addition, RN/LALD-A stated the resident's records should include prescriptions for each medication administered by licensee and prescriptions should be renewed yearly. The licensee's Medication & Treatment Orders policy dated August 1, 2021, indicated licensee will ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	01970		

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01970	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R1) using oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted for assisted living services October 27, 2021. R1's diagnoses included chronic obstructive pulmonary disease (COPD) (a type of progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), seizure disorder, morbid obesity, and anxiety. R1's Service Plan (Wavier)- Addendum to Contract dated March 30, 2023, indicated R1 received assistance with oxygen delivery, non-medical transportation, housekeeping, laundry, and medication administration. OXYGEN R1's Services Delivered - One Resident dated between January 1, 2023, to February 28, 2023, indicated R1 received oxygen delivery three times	01970		

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01970	Continued From page 25 daily. R1's signed provider orders dated January 20, 2023, indicated R1 received oxygen delivery daily, but lacked the flow rate and the resident parameters. R1's Nursing notes dated February 24, 2023, indicated R1 was using oxygen as needed. On April 5, 2023, at 11:26 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated prescriptions for treatments and therapy are obtained from pharmacy but had not received the current orders for oxygen. In addition, RN/LALD-A stated the resident's records should include prescriptions for each treatment or therapy done by licensee and prescriptions should be renewed yearly. The licensee's Medication & Treatment Orders policy dated August 1, 2021, indicated licensee will ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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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
02310	Continued From page 26 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1) when the licensee failed to ensure supplemental oxygen (O2) tanks were stored safely to prevent tipping. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's signed service plan dated March 30, 2023, indicated R1 received services including oxygen delivery, grooming, group socialization, housekeeping, laundry, linen change, medication management, manage behaviors and symptoms, meal assistance, money management, non-medical transport, one on one socialization, vitals, and shopping assistance. On April 4, 2023, at 1:20 p.m., during an Environmental Engineer (EE) facility inspection, the environmental engineer observed R1's closet contained multiple metal O2 tanks, standing upright on the floor, and not secured to prevent	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36907	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COZY BARAKA HOME CARE INC	3554 BOONE 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
02310	Continued From page 27 tipping. -at 2:10 p.m., the surveyor went into R1's bedroom for observations and noted 11 metal O2 tanks in R1's closet. The O2 tanks were not secured to prevent tipping. On April 5, 2023, at 2:30 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated she was not aware of the O2 cylinders in the closet. RN/LALD-A stated she was aware O2 tanks should be secured to prevent tipping and would request a storage rack from the O2 supply company. RN/LALD-A stated safe storage was part of staff training on assisting with O2. The licensee policy 7.40 Oxygen dated August 1, 2021, indicated oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or roll it to a new location. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements (based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code), dated April 16, 2020, indicated the types of hazards associated with oxygen as: 1) General fires and explosions enhanced by oxygen-rich atmospheres 2) Mechanical problems such as physical damage to compressed gas cylinders. The guidance further indicated, "when storing up to 300 cubic feet (ft^3) of oxygen, cylinders must be secured (chains or racks) to prevent them from falling over". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36907	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COZY BARAKA HOME CARE INC	3554 BOONE 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
02310	Continued From page 28 days	02310		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *04/04/23*
Time: 15:04:54
Report: 7994231081

Food and Beverage Establishment Inspection Report

Location:

Cozy Baraka Home Care
3554 Boone Avenue North
New Hope, MN55427
Hennepin County, 27

Establishment Info:

ID #: 0037815
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122429073
ID #:

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

No NEW orders were issued during this inspection.

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH 6-8 INCH LEGS, SOLID COUNTER TOPS AND SMOOTH CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

Food and Beverage Establishment Inspection Report

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 7994231081 of 04/04/23.

Certified Food Protection Manager: Rahel Aron

Certification Number: 111200 Expires: 05/02/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Crystal Elva

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994231081

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	0	**Date**	04/04/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	15:04:54
Legal Authority MN Rules Chapter 4626		**Time Out**	

Cozy Baraka Home Care	**Address** 3554 Boone Avenue North	**City/State** New Hope, MN	**Zip Code** 55427	**Telephone** 6122429073
License/Permit # 0037815	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status					COS	R
Surpervision						
1	(IN)	OUT		PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A	Certified food protection manager, duties		
Employee Health						
3	(IN)	OUT		Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT		Proper use of reporting, restriction & exclusion		
5	(IN)	OUT		Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices						
6	(IN)	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT	N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands						
8	(IN)	OUT	N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT		Adequate handwashing sinks supplied/accessible		
Approved Source						
11	(IN)	OUT		Food obtained from approved source		
12	IN	OUT	N/A (N/O)	Food received at proper temperature		
13	(IN)	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination						
15	(IN)	OUT	N/A N/O	Food separated and protected		
16	(IN)	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status					COS	R
Time/Temperature Control for Safety						
18	IN	OUT	N/A	(N/O) Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O Proper cooling time & temperature		
21	IN	OUT	(N/A)	N/O Proper hot holding temperatures		
22	(IN)	OUT	N/A	Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O Time as a public health control: procedures & records		
Consumer Advisory						
25	IN	OUT	(N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations						
26	IN	OUT	(N/A)	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances						
27	IN	OUT	(N/A)	Food additives: approved & properly used		
28	(IN)	OUT		Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures						
29	IN	OUT	(N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

				COS	R
Safe Food and Water					
30	IN	OUT	(N/A) Pasteurized eggs used where required		
31			Water & ice obtained from an approved source		
32	IN	OUT	(N/A) Variance obtained for specialized processing methods		
Food Temperature Control					
33			Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	(N/A) N/O Plant food properly cooked for hot holding		
35	IN	OUT	N/A (N/O) Approved thawing methods used		
36			Thermometers provided & accurate		
Food Identification					
37			Food properly labled; original container		
Prevention of Food Contamination					
38			Insects, rodents, & animals not present		
39			Contamination prevented during food prep, storage & display		
40			Personal cleanliness		
41			Wiping cloths: properly used & stored		
42			Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 04/12/23

Inspector (Signature) Crystal Elva