



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 2, 2024

Licensee

Millennium Home Senior Care

1830 Summer Avenue East

Maplewood, MN 55109

RE: Project Number(s) SL36351015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 15, 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.

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 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.

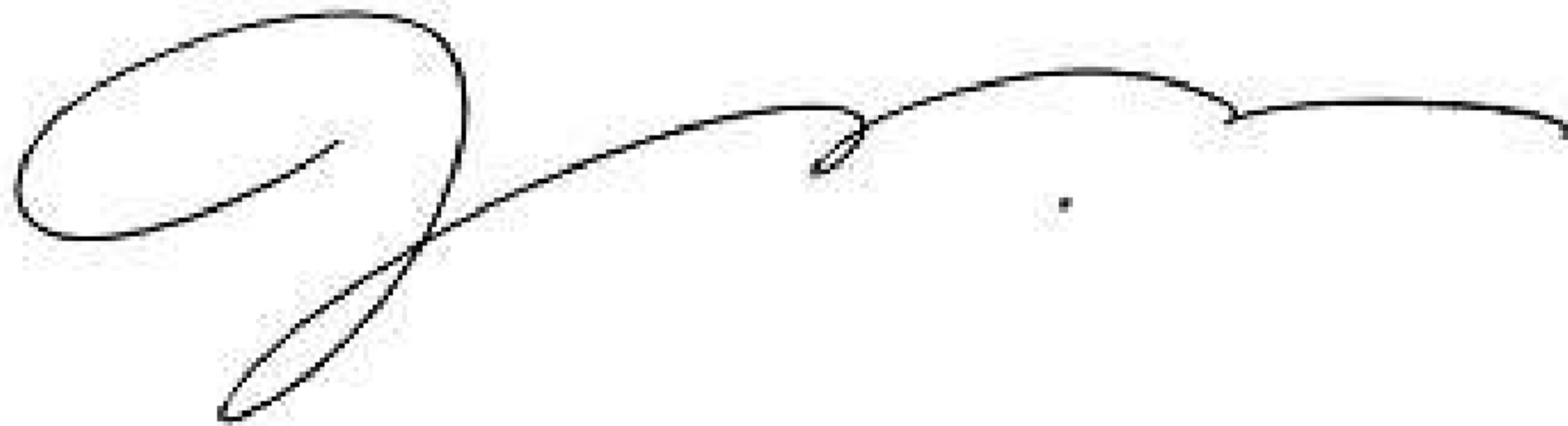
To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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,

A handwritten signature in black ink, appearing to read 'Jess Schoenecker', with a stylized flourish at the end.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/15/2023
NAME OF PROVIDER OR SUPPLIER MILLENNIUM HOME SENIOR CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1830 SUMMER AVENUE EAST MAPLEWOOD, MN 55109		
(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: SL36351015-0 On December 11, 2023, through December 15, 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 3 active residents; 3 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the staffing plan was posted as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 470			

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0 470	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 11, 2023, at approximately 10:30 a.m., during a tour of the facility, the surveyor did not observe a posted staff schedule after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On December 11, 2023, at approximately 10:45 p.m., licensed assisted living director (LALD)-A stated the licensee was not aware a staffing schedule was required to be posted for residents, staff, and visitors to be able to access in common area. No further information 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: (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	0 480			

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0 480	Continued From page 3 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 December 11, 2023, 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			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a	0 485			

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0 485	Continued From page 4 food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all current residents, This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On December 11, 2023, at approximately 10:00 a.m., during entrance conference, licensed assisted living director (LALD)-A stated the licensee provided three meals daily and snacks twice daily. On December 11, 2023, at approximately 10:30 a.m., during a facility tour the kitchens and/or common areas lacked a menu prepared at least one week in advance and made available to all residents. On December 11, 2023, at approximately 10:45 p.m., (LALD)-A stated the licensee was not aware	0 485			

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0 485	Continued From page 5 a menu must be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities	0 490			

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0 490	Continued From page 6 for active participation in the community at large. This had the potential to affect all residents of the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On December 11, 2023, at 10:00 a.m., during the entrance conference licensed assisted living director (LALD)-A stated licensee had a daily program of social and recreational activities provided for the residents. On December 11, 2023, during the course of the survey on site, the surveyor did not observe recreation or daily program of social and recreational activities provided by the licensee. On December 11, 2023, at 2:30 p.m., registered nurse (RN)-B stated licensee performs activities with the residents but is not documented. RN-B stated the residents were able to request activities, but licensee had not developed a schedule of activities for residents who resided under the licensee's care. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490			

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0 550	Continued From page 7	0 550			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 550			

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0 550	Continued From page 8 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During a facility tour on December 11, 2023, at approximately 10:30 a.m., the common areas shared by residents, staff, and visitors, the required posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On December 11, 2023, at approximately 10:45 a.m., licensed assisted living director (LALD)-A acknowledged the required content was not posted in the common areas and was not aware of this posting requirement. The licensee's Vulnerable Adult policy dated March 1, 2020, lacked indication for posting information of the regional Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities information. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			

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0 570	Continued From page 9	0 570			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the current assisted living license at the main entrance of the assisted living building. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at approximately 10:30 a.m., the surveyor did not observe an original posted current license posted at the licensee's main entrance during a tour of the facility. On December 11, 2023, at approximately 10:45 p.m., licensed assisted living director (LALD)-A stated the licensee was not aware a current assisted living license was required to be posted at the main entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 570			

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0 570	Continued From page 10 (21) days	0 570			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. 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) 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:	0 580			

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0 580	Continued From page 11 On December 11, 2023, at approximately 10:15 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee was not aware of the QMP requirement and one had not been developed or implemented. LALD-A stated the licensee provided ongoing improvement as areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. The licensee's Quality Improvement policy dated March 1, 2020, indicated a QMP would be implemented, and documentation would be provided upon request. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660			

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0 660	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment. 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 December 11, 2023, at approximately 10:30 a.m. during the entrance conference, licensed assisted living director (LALD)-A acknowledged the licensee had not completed a facility TB risk assessment and was not aware of this requirement. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The licensee's Tuberculosis Screening/Prevention policy dated March 1, 2020, indicated a facility TB risk assessment would be	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/15/2023
NAME OF PROVIDER OR SUPPLIER MILLENNIUM HOME SENIOR CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1830 SUMMER AVENUE EAST MAPLEWOOD, MN 55109		
(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
0 660	Continued From page 13 completed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses 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 observation and interview, the licensee	0 680			

Minnesota Department of Health

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0 680	Continued From page 14 failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, 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 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 December 11, 2023, at approximately 2:00 p.m., licensed assisted living director (LALD)-A provided a binder and indicated the contents were the licensee's EPP. The licensee's EPP undated, lacked documentation including all the required elements of: -annual review; -missing resident quarterly review; -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for EP cooperation with state and local EP officials/organizations; -development of all policies/procedures (P/P), based on HVA assessment; -development of a communication plan; and -EP training and testing program. On December 11, 2023, at approximately 3:00 p.m., LALD-A acknowledged the licensee's EPP lacked the above listed required content and was	0 680			

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0 680	Continued From page 15 not unaware of all the requirements of Appendix Z. The licensee's Emergency Preparedness policy dated March 1, 2020, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	0 780			

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0 780	Continued From page 16 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 the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, from 10:00 a.m. to 11:15 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. It was observed the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit so the actuation of one alarm would cause all alarms to operate. LALD-A verified this deficient finding at the time of discovery. During interview on December 12, 2023, at 3:00 p.m., LALD-A stated they were currently shopping for interconnected smoke alarms. Survey staff reviewed the required locations with LALD-A to	0 780			

Minnesota Department of Health

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0 780	Continued From page 17 ensure future compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 790			

Minnesota Department of Health

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0 790	Continued From page 18 On December 11, 2023, from 10:00 a.m. to 11:15 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the tour, survey staff observed both portable fire extinguishers in the facility lacked any tag or documentation showing the required annual certification and monthly visual inspections to date. All fire extinguishers in the licensed facility must be properly maintained. The licensee failed to complete monthly and annual maintenance as required. LALD-A visually verified this deficient finding at the time of discovery. During interview on December 12, 2023, at 3:00 p.m., LALD-A stated they had done the annual certification maintenance but could not find the documentation. LALD-A acknowledged the deficiency and stated he would start completing the required annual certification and monthly visual inspections. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810			

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0 810	Continued From page 19 (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 the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810			

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0 810	Continued From page 20 or has potential to affect a large portion or all of the residents). The findings include: On December 12, 2023, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP, titled "Fire Safety", dated April 20, 2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Remove, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff	0 810			

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0 810	Continued From page 21 to follow in case of relocation. During an interview on December 12, 2023, at 3:00 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-A was unable to provide documentation showing any training offered to residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evidenced by the "Staff In-Service Training with CEU" report provided by an online third-party platform. LALD-A was unable to provide documentation showing each staff member had received the two required trainings on facility-specific plans. No other documentation was provided. During an interview on December 12, 2023, at 3:00 p.m., LALD-A stated residents participate in the fire drills but are not offered any training. LALD-A also stated staff receive training on the FSEP twice per year but could not provide any additional documentation that showed compliance with training requirements. Survey staff reviewed training requirements for residents and staff on the FSEP. LALD-A stated they understood the areas of their training that were insufficient and would work on bringing them into compliance. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per	0 810			

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0 810	Continued From page 22 year, per shift with at least one evacuation drill every other month as evidenced by the fire drill reports provided. Evacuation drills were conducted on 05/07/2023 and 09/09/2022. No other documentation was provided. During an interview on December 12, 2023, at 3:00 p.m., LALD-A stated there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the licensee's current health facility	01290			

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01290	Continued From page 23 identification (HFID) for one of one employee (unlicensed personnel (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 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: ULP-C was hired on April 3, 2023. ULP-C's employee record included a BGS clearance dated March 31, 2023, affiliated with the licensee's previous HFID #35709. ULP-C's employee record lacked evidence of current, cleared BGS affiliated with the licensee's assisted living HFID #36351. On December 11, 2023, at approximately 1:45 p.m., the Minnesota Department of Human Services NETStudy2 website indicated ULP-C's BGS was not affiliated with HFID #36351. On December 11, 2023, at approximately 2:00 p.m., licensed assisted living director (LALD)-A stated the BGS for ULP-C was performed under the wrong HFID by mistake in the drop-down box on the DHS web site. The licensee's Recruitment and Hiring policy dated March 1, 2020, indicated the licensee complies with all state regulations for pre-employment background checks/studies required for all employees.	01290			

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01290	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 10:00 a.m., upon entering the facility, the surveyor observed two	03090			

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03090	Continued From page 25 entrances accessible by visitors to the facility, but each lacked the required notice for electronic monitoring. On December 11, 2023, at approximately 10:30 a.m. during a facility tour, multiple cameras were noted throughout the facility. On December 11, 2023, at 10:45 a.m., licensed assisted living director (LALD)-A stated the licensee was not aware of the required verbatim notice to be posted at each entrance accessible by visitors. LALD-A stated the required postings would need to be placed at each entrance. The licensee's Electronic Monitoring policy dated March 1, 2020, indicated the licensee will post an electronic monitoring sign at each facility entrance accessible to visitors. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 12/11/23
Time: 14:24:10
Report: 1021231414

Food and Beverage Establishment Inspection Report

Page 1

Location:

Millennium Home Senior Care
1830 Summer Avenue East
Maplewood, MN 55109
Ramsey County, 62

Establishment Info:

ID #: 0039300
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513304729
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.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH OWNER. AN MDH EMPLOYEE ILLNESS LOG LEFT ON-SITE.

Comply By: 12/11/23

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.

A CARTON OF RAW SHELL EGGS FOUND STORED ABOVE READY TO EAT VEGGIES IN THE KITCHEN WHIRLPOOL REFRIGERATOR. OWNER WILL MOVE CARTON OF RAW SHELL EGGS TO BOTTOM SHELF TO PREVENT ANY CROSS CONTAMINATION. CORRECTED ON-SITE.

Comply By: 12/11/23

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.

ESTABLISHMENT DOES NOT HAVE PROCEDURES IN PLACE ON HOW TO CLEAN UP A

Type: Full
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VOMITING/FECAL ACCIDENT. INFORMATION ON HOW TO PROPERLY CLEAN UP AN ACCIDENT SENT WITH REPORT. TRAIN EMPLOYEES TO CLEAN UP ACCIDENTS.

Comply By: 12/18/23

4-300 Equipment Numbers and Capacities

4-302.12A ** Priority 2 **

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

ESTABLISHMENT DOES NOT HAVE A FOOD THERMOMETER ON-SITE. PROVIDE A DIGITAL THERMOMETER WITH A SMALL DIAMETER PROBE AS DESCRIBED IN RULE ABOVE.

Comply By: 12/18/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PROVIDE. THERMOLABELS LEFT ON-SITE.

Comply By: 12/18/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 12/18/23

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. STAFF ARE IN THE PROCESS OF GETTING THEIR CFPM CERTIFICATES. CFPM INFORMATION SENT WITH REPORT.

Comply By: 01/11/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETER IN THE WHIRLPOOL REFRIGERATOR. PROVIDE A THERMOMETER IN THE WARMEST PART OF THE REFRIGERATOR AS DESCRIBED IN RULE ABOVE.

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4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

GREASE ACCUMULATION ON THE GREASE FILTER UNDER THE MICROWAVE. CLEAN GREASE ON THE CABINETS AND CEILING. DRIED FOOD DEBRIS AND SPILLED LIQUIDS ON THE BOTTOM SHELF IN THE BASEMENT UPRIGHT FREEZER. CLEAN AND MAINTAIN CLEAN.

Comply By: 12/15/23

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

BATHROOM IN THE MAIN FLOOR IS MISSING A HANDWASHING SIGN THAT REMINDS FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 12/15/23

Food and Equipment Temperatures

Process/Item: Ambient Temperature

Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: TOFU - WHIRLPOOL REFRIGERATOR

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	4	4

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH OWNER, VINCENT THAO AND HEALTH REGULATION DIVISION NURSE EVALUATOR, CARL SAMROCK.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH STAFF, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, VINYL FLOORING AND PAINTED BRICKWALL. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

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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 1021231414 of 12/11/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

VINCENT THAO
OWNER

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us