



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 8, 2024

Licensee

MN Best Homecare, LLC

6264 Sunrise Terrace

Brooklyn Park, MN 55428

RE: Project Number(s) SL37013015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 7, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine

of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" written in a larger, more prominent script than the last name "DeVries".

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6264 SUNRISE TERRACE BROOKLYN PARK, MN 55428		
(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: SL37013015-0 On March 4, 2024, through March 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, all residents received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250			

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 4, 2024, at 9:30 a.m., licensed assisted living	0 250			

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0 250	Continued From page 3 director/clinical nurse supervisor (LALD/CNS)-D stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250			

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0 250	Continued From page 4 may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all	0 250			

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0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD/CNS-D on July 19, 2023. The licensee had an assisted living license issued November 1, 2023, with an expiration date of October 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; and - medication and treatment management. On March 7, 2024, at 12:59 p.m., LALD/CNS-D confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0470, 0480, 0485, 0510, 0570, 0640,	0 250			

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0 250	Continued From page 6 0680, 0700, 0780, 0800, 0810, 1290, 1530, 1620, 1730, 1820, 1880, 1890, 1910, 1940, 1970, and 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	0 470			

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0 470	Continued From page 7 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required per Minnesota Administrative Rule 4659.0810 subpart 4. b. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 4, 2024, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the staff schedule was located in the communication book by the nursing station. March 4, 2024, at 10:50 a.m., during a facility tour, the surveyor observed a staff schedule dated February 2024 on the counter near the nursing station. The schedule included February 1, 2024, through February 29, 2024, four days of undated scheduling prior to February 1, 2024, and nine days of undated scheduling after February 29, 2024. The posting lacked the	0 470			

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0 470	Continued From page 8 current schedule. Licensed practical nurse/agent (LPN/A)-C stated the schedule continued into March however, they were not labeled with the dates. LPN/A-C stated they were aware of the requirement and stated it was an oversight. The licensee's undated Assisted Living Staffing Policy, indicated the facility shall maintain compliance with staffing regulation and requirement set forth by the state licensing agencies and accrediting bodies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 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	0 480			

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0 480	Continued From page 9 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 March 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 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 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	0 485			

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0 485	Continued From page 10 by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the 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 of the residents). The findings include: On March 6, 2024, at 8:12 a.m., LALD/CNS-D provided a blank contract titled Resident Contract for Assisted Living and stated this was the contract used for all residents. The licensee's Assisted Living Contract page 13 titled Attachment A included: "This Assisted Living Facility offers all of the following (included in the Month Base Fee): - At least three meals daily with snacks available seven (7) days per week." The licensee's Resident Contract for Assisted Living lacked the option to opt out of the meal plan. On March 6, 2024, at 8:14 a.m., LALD/CNS-D stated the statement should not be included in the contract, "we will correct". The licensee's undated Meals Policy indicated the licensee complied with all applicable federal,	0 485			

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0 485	Continued From page 11 state, and local regulations regarding food safety, sanitation, and dietary services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to sharps disposal. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 510			

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0 510	Continued From page 12 was issued at an widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 4, 2024, at 12:10 p.m., during a facility tour, in the lower-level of the facility, in a small closet, there was a small blue crate that contained three red biohazard sharps containers. One biohazard sharps container had items protruding out of the top and could not be secured with a container lid. The only identifiable item protruding from the top of the sharps container was a pair of scissors. On March 4, 2024, at 12:11 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated a person had placed the scissors into the biohazard container and "it's not supposed to be like that". LALD/CNS-D stated a lid should be used to secure the biohazard container. The United States Food and Drug Administration (FDA) document titled Sharps Disposal Containers in Health Care Facilities dated April 29, 2021, recommended sharps containers should be closed and sealed when about 3/4 full. The licensee's undated Hazardous Materials Management policy indicated sharps should be disposed of in an approved puncture-resistant container with an international biohazard symbol, containers should have a closable lid and be leak proof, and containers should not be filled above the identified fill line. No further information was provided.	0 510			

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0 510	Continued From page 13	0 510			
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, interview, and record review the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. 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: The licensee held an assisted living license effective November 1, 2023, with an expiration date of October 31, 2024. On March 4, 2024, at 10:50 a.m., the surveyor observed the licensee had posted and expired Assisted Living Facility license in the facility's living room near the main entrance. Effective date of the license posted in the common area expired	0 570			

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0 570	Continued From page 14 on October 31, 2023. On March 4, 2024, at 12:58 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they thought the new license was posted and were aware a current license should be displayed. On March 4, 2024, at 1:07 p.m., the surveyor observed LALD/CNS-D remove the expired license from the frame and place the current license into the frame. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not	0 640			

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0 640	Continued From page 15 posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 March 4, 2024, at 10:50 p.m., during a facility tour, the surveyor observed a cordless phone charger in the living room, and on the counter-top in the kitchen. In addition, the surveyor observed the facility's main entry area and common areas lacked the required post information as followed: - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility; and - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On March 4, 2024, at 12:53 p.m., unlicensed personnel (ULP)-E stated the cordless phone was used by staff and residents. On March 4, 2024, at 12:58 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the residents had their own	0 640			

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0 640	Continued From page 16 personal cell phones, and the cordless phone was only used in emergencies. LALD/CNS-D stated residents cannot dial without assistance. On March 5, 2024, at 12:19 p.m., the surveyor inquired if the licensee posted the required MAARC contact information. LALD/CNS-D stated the display board included Ombudsman information but did not include MAARC information. On March 6, 2024, at 11:42 a.m., LALD/CNS-D stated the missed posting were "just an oversight". The licensee's undated MN Statutes 626.557, 144G.42, Subd.6 Reporting Maltreatment of Vulnerable Adult indicated the facility will post 911 emergency number near telephones within the assisted living facility (ALF) and post MAARC contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680			

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0 680	Continued From page 17 (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 plan (EPP) 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 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 emergency disaster preparedness plan lacked evidence of the following required content:	0 680			

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0 680	Continued From page 18 - annual review; - hazard vulnerability risk assessment; - quarterly review of missing resident policy; - emergency plan (EP) patient population; - process for EP collaboration; - subsistence needs for staff and residents; - procedures for tracking staff and residents; - policies and procedures for evacuation including transportation, identification of evacuation locations, primary communication means with external sources of assistance; - policy 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 to include resident's physicians - emergency officials contact information to include regional and local EP staff, and state licensing and certification agency; - primary means for communication; - methods for sharing information; - sharing information on occupancy/needs; and - long term care family notifications; and emergency prep testing requirements. On March 6, 2024, at 9:03 a.m., licensed practical nurse/agent (LPN/A)-C stated the EPP should be updated yearly and the last time they reviewed the licensee EPP was the "earlier part of last year." LPN/A-C stated they do not document when they review the EPP. LPN/A-C stated they were not familiar with all the requirements of Appendix Z. LPN/A-C stated they reviewed the missing resident policy every six months, however, did not have documentation to show the last time the policy was reviewed. LPN/A-C stated they conducted drills once a year.	0 680			

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0 680	Continued From page 19 On March 6, 2024, at 9:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they were not aware of all the required content for Appendix Z and stated they would contact a local trade organization for more information. The licensee's undated Emergency Management Policy indicated the facility would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for four of four residents (R1, R3, R4, R5).	0 700			

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0 700	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, 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). These finding include: On March 4, 2024, at 10:59 a.m., during facility tour, the surveyor observed a document titled Shower Schedule posted in the dining room. The document included R1, R3, and R4's shower schedule. In addition, there was an untitled document that contained R4's shower information, and a calendar that contained R1 and R5's appointments. On March 4, 2024, at 11:05 a.m., licensed practical nurse/agent (LPN/A)-C stated residents used the dining room to visit with staff and eat. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated, "it is just a shower schedule." LALD/CNS-C agreed the residents would be able to visualize the documents posted and stated if the documents included a resident's name, it was not appropriate to post on the wall. LALD/CNS-C removed the documents. On March 4, 2024, at 11:32 a.m., during a facility tour, the surveyor observed five bedrooms labeled one, two, three, four, and five on the facility's upper level. In unoccupied room number two, accesable to staff, residents, and visitors, the surveyor observed a green folder with a label, "[R3] ILS [R3 phone number] manager [manager	0 700			

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0 700	Continued From page 21 name] LSW". The folder contained health insurance correspondences, disability correspondences and one envelope addressed to R3. On March 4, 2024, at 11:32 a.m., LALD/CNS-D stated records should be secured for all residents. LALD/CNS-D identified the documents and envelope belonged to R3 and did not know why these documents were in room 2. On March 4, 2024, at 11:52 a.m., R3 stated they moved into bedroom two for a month when an electrical outlet caught fire in room three. On March 5, 2024, at 12:15 p.m., LALD/CNS-D stated R3 had lived in room two for a period of time and the documents and envelope did not get transferred with R3 when they changed rooms. LALD/CNS-D stated the documents and envelope should have been secured. The licensee's undated Minnesota Bill of Rights for Assisted living Residents policy indicated residents had the right to respect and privacy regarding the resident's service plan and residents had the right to have personal, financial, health and medical information kept private. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
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	0 780			

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0 780	Continued From page 22 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling 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	0 780			

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0 780	Continued From page 23 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 04, 2024, at 12:46 p.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D, survey staff observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the LALD/CNS-D tested the smoke alarms and could not be heard throughout the facility. LALD/CNS-D verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the	0 800			

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0 800	Continued From page 24 residents. This had the potential to directly affect some of the 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 March 04, 2024, at 12:15 p.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D, it was observed that one of the emergency exit doors exited out into the garage. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the garage. This exit door was included on the fire safety evacuation plan. It was also found that resident room #5 had black burn marks around the plug-in outlet on the wall. Also observed that there were damaged ceiling tiles in the basement living room and bathroom. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810			

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0 810	Continued From page 25 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to	0 810			

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0 810	Continued From page 26 conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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: A record review and interview were conducted on March 06, 2024, at 10:41 a.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the evacuation plan did not include employee actions to be taken in the event of a fire or similar emergency. The current plan uses the RACE acronym which is very basic and does not show the employees actions in the event of a fire or similar emergency. Record review of the available documentation indicated that the evacuation plan did not include complete procedures for residents' evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan uses the RACE acronym which is very basic and does not show the residents actions in the event of a fire or similar emergency.	0 810			

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0 810	Continued From page 27 Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed evacuation drills being done every six months. During a phone interview, LALD/CNS-D verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=F	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 observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three	01290			

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01290	Continued From page 28 of five employees (unlicensed personnel (ULP)-E, ULP-F, ULP-G). 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-E was hired on May 16, 2023, to perform direct care to residents. On March 5, 2024, at 8:24 a.m., the surveyor observed ULP-E administer oral medication to R1. ULP-E's employee record contained a background study clearance dated May 23, 2023, affiliated to licensee's sister facility HFID 36617. ULP-B's record lacked evidence the licensee submitted a background study for ULP-E under the current assisted living license and affiliated to the current HFID number. On March 4, 2024, at 10:48 a.m., the surveyor compared the licensee's NETStudy 2.0 roster (a web-based system used to submit background study requests to the Department of Human Services) for HFID 35019 to the licensee's employee list. The surveyor observed ULP-E, ULP-F, and ULP-G were not on the roster. On March 4, 2024, at 12:58 p.m., the surveyor reviewed the NETStudy 2.0 for the employees ULP-F and ULP-G and observed the following	01290			

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01290	Continued From page 29 employees affiliated to licensee's sister facilities: - ULP-F affiliated to 36617; and - ULP-G affiliated to 32875. On March 5, 2024, at 11:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they conducted background studies on each employee and the licensee affiliated the background study to the licensee. On March 5, 2024, at 11:35 a.m., LALD/CNS-D stated ULP-E worked at a sister facility in Blaine until a couple weeks ago. LALD/CNS-D stated ULP-F worked at a sister facility and now was an on-call employee. LALD/CNS-D stated ULP-G worked under the active comprehensive license of a sister licensee. LALD/CNS-D stated if the ULP began employment at a sister facility, the licensee would affiliate the ULP to the licensee's HFID if there was a need, or a month or more after the ULP transferred. The licensee's undated Background Studies policy indicated each employee, volunteer, and contractor who would provide direct care to the residents must have a background study completed prior to working. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements:	01530			

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01530	Continued From page 30 (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 received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of two unlicensed personnel ((ULP)-B, ULP-E). In addition, the licensee failed to ensure a supervisor of direct-care employees received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of one nurse (licensed practical nurse/agent (LPN)-C).	01530			

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01530	Continued From page 31 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: ULP-B ULP-B was hired on May 13, 2023, to perform direct care to residents. ULP-Bs employee record included seven hours and 15 minutes of initial training on dementia completed between July 18, 2023, and September 6, 2023. The employee record lacked the required eight hours of dementia training to be completed with 160 hours of employment. ULP-E ULP-E was hired on May 16, 2023, to perform direct care to residents. ULP-E's employee record included seven hours and 15 minutes of initial training on dementia completed between May 18, 2023, and August 3, 2023. The employee record lacked the required eight hours of dementia training to be completed with 160 hours of employment. LPN/A-C LPN/A-C was hired on August 30, 2017, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents.	01530			

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01530	Continued From page 32 LPN/A-C's employee record included seven hours and 45 minutes of initial training on dementia completed on April 1, 2023. The employee record lacked the required eight hours of dementia training to be completed with 120 hours of employment. On March 5, 2024, at 11:42 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D verified the number of hours for LPN/A-C, and stated they would look to see if LPN/A-C completed other dementia care training from Care Providers. On March 5, 2024, at 11:53 a.m., LALD/CNS-D verified ULP-B's hours of dementia training. LALD/CNS-D stated employees should receive eight hours of initial dementia care training from EduCare (a training software). LALD/CNS-D stated they believed staff may have not completed trainings assigned in EduCare. LALD/CNS-D stated they would look at the office for LPN/A-C, ULP-B, and ULP-E's dementia care training. On March 5, 2024, at 6:23 via email correspondence, the surveyor received dementia care training for LPN/A-C, ULP-B, and ULP-E, which was completed during the survey. On March 6, 2024, at 11:56 a.m., the surveyor inquired why the licensee provided dementia care training for LPN/A-C, ULP-B, and ULP-E that was completed during the survey. LALD/CNS-D stated they were unable to find additional dementia care training "so I made them do it." The licensees undated Dementia Care Training policy indicated direct care employees must have completed eight hours of initial dementia training	01530			

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01530	Continued From page 33 on required topics in 160 hours from employment start date. Supervisors of direct-care staff must have at least eight hours of initial dementia care training within 120 working hours of employment start date. Until the training was complete, the employee must not provide direct care unless there was another employee onsite who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if an issue arises. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620			

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01620	Continued From page 34 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to perform a comprehensive uniform assessment as required per Minnesota Administrative Rule 4659.0150 for one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on November 29, 2019, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R1's diagnosis included quadriplegic, attention deficit hyperactive disorder, spinal cord injury at cervical (C) level C1-C4, depression, anxiety, constipation, urinary tract infection, seizure disorder, cystitis (inflammation of the bladder), insomnia, patients noncompliance with other medical treatment and regimen, tobacco use disorder, pressure ulcer wound to right buttock, acute cystitis with hematuria (blood in urine), and chronic suprapubic catheter (urinary drain in the	01620			

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01620	Continued From page 35 abdomen). R1's MN Service Plan (Waiver) - Addendum to Contract dated October 29, 2019, indicated R1 received assistance with activities, bathing assistance, behavior management, catheter care, dressing, drinking assistance, exercise/passive range of motion, grooming, housekeeping, laundry, meal assistance, medication administration, medication setup, record bowel movement, repositioning, skin care, toileting, and transfer assistance. R1's record included a document titled ACH Advanced Comfort Health dated March 5, 2024, that indicated R1 had a wound on the sacrum/buttock and left gluteus and received wound care on Tuesday, Thursday, and Saturday. Minnesota Administrative Rule 4659.0150 for uniform assessment tool required the licensee to include the following information for each resident: -the resident's personal lifestyle preferences; -activities of daily living; -instrumental activities of daily living; -physical health status; -emotional and mental health conditions; -cognition; -communication and sensory capabilities; -pain; -skin conditions; -nutritional and hydration status and preferences; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk indicators; -who has decision-making authority for the resident, and;	01620			

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01620	Continued From page 36 -the need for follow-up referrals for additional medical or cognitive care by health professionals. R1's Assessment dated January 20, 2024, performed by the registered nurse indicated R1 had dry and flaky skin and indicated to apply lotion to affected area. The registered nurse assessment for R1 lacked the following information: -physical health status: compromised skin (wounds) -pain: no pain scale obtained; -skin condition, with interventions: failed to state an outside wound care agency was performing wound care; -list of treatments: current wound care that was administered, how often wound care was provided, and; -nursing needs: what unlicensed personnel (ULP) should do if a problem happened with the current dressing. On March 4, 2024, at 10:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the licensee conducted nursing assessments upon admission, day 14, day 30, then every 90 days or if there was a change in condition. On March 4, 2024, at 2:17 p.m., R1 stated they had a wound that was cared for by an outside agency unless the agency was unavailable then the licensee would assist with wound care. On March 6, 2024, at 11:38 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated, "[R1] wound care is taken care of by an outside agency" and "we don't do anything besides monitoring." The surveyor inquired if the licensee ever changed R1's	01620			

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01620	Continued From page 37 dressing if it was soiled. LALD/CNS-C stated ULPs were trained to perform wet to dry dressing (using saline soaked gauze, placing it in the wound for it to dry) if a resident's dressing became visibly soiled and then would report the facility nurse. LALD/CNS-C stated the licensee's licensed nurse would then come into the facility change the wet to dry dressing to the prescribed treatment. The licensee's undated policy titled MN Statute: 144G.71 Subd 1,2,3 Nursing Assessment and Reassessment of Residents indicates the RN would perform a new assessment based on a change of condition with a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6264 SUNRISE TERRACE BROOKLYN PARK, MN 55428		
(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
01730	Continued From page 38 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of three residents (R1, R5). 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	01730			

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01730	Continued From page 39 was issued at an pattern 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 R1 admitted to the licensee on November 29, 2019, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R1's diagnosis included quadriplegic, attention deficit hyperactive disorder, spinal cord injury at cervical (C) level C1-C4, depression, anxiety, constipation, urinary tract infection, seizure disorder, cystitis (inflammation of the bladder), insomnia, patients noncompliance with other medical treatment and regimen, tobacco use disorder, pressure ulcer wound to right buttock, acute cystitis with hematuria (blood in urine), and chronic suprapubic catheter (urinary drain in the abdomen). R1's MN Service Plan (Waiver) - Addendum to Contract dated October 29, 2019, indicated R1 received assistance with activities, bathing assistance, behavior management, catheter care, dressing, drinking assistance, exercise/passive range of motion, grooming, housekeeping, laundry, meal assistance, medication administration, medication setup, record bowel movement, repositioning, skin care, toileting, and transfer assistance. R1's medication administration record (MAR) dated February 1, 2024, through February 29, 2024, indicated the following medications: amphetamine/dextroamphetamine cap 25	01730			

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01730	Continued From page 40 milligram (mg) extended release (ER) daily, baclofen 20 mg four times daily, duloxetine 60 mg daily, gabapentin 300 mg 2 capsules four times daily, metronidazole 500 mg crush and apply topically (to the skin) with dressing changes, nystatin powder 60 grams (g) twice daily, Butt paste daily, acetaminophen six times daily as needed, and bisacodyl 10 mg suppository. On March 5, 2024, at 8:24 a.m., the surveyor observed ULP-E administer baclofen 20 milligrams (mg), duloxetine 60 mg, gabapentin 600 mg, metronidazole 500 mg, and amphetamine/dextroamphetamine 25 mg to R1. R1's Individualized Medication Management Plan dated October 25, 2024, lacked the following information: - documentation of specific resident instructions to the administration of medications: did not included oral route of medications; and - identification of medication management tasks that may be delegated to the unlicensed personnel (ULP). R5 R5 admitted to the licensee on April 13, 2023, and began receiving assisted living services. R5's diagnosis included spinal cord injury at thoracic (T) level T1-T6, methamphetamine use disorder severe dependance, antisocial personality disorder, paraplegia, wound of buttock, adjustment disorder with mixed disturbance of emotions and conduct, post-traumatic stress disorder, encephalopathy psychosis (brain disease that alters the brain function or structure, perceptions are disrupted and have difficulty in recognizing what is real and what is not), left shoulder pain, substance	01730			

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01730	Continued From page 41 induced psychosis/substance use disorder, and fractures of the left posterior first and second ribs. R5's Service Plan (Waiver) - Addendum to Contract dated April 13, 2023, indicated R5 received assistance with activities, bathing assistance, behavior management, dressing, drinking assistance, grooming, housekeeping, irrigation/flush of catheter, laundry, meal assistance and preparation, medication administration, medication setup, repositioning, skin care, toileting, transfer assistance, wound care, and monitoring of bowel movement, output, and temperature. R5's MAR dated February 1, 2024, through February 29, 2024, indicated R5 received the following medications: bacitracin ointment apply to catheter daily, atomoxetine 40 mg once daily, baclofen 10 mg three times daily, gabapentin 300 mg three times daily, lurasidone 60 mg half tablet once daily, oxybutynin 10 mg ER once daily, venlafaxine 75 mg ER once daily, Ma-Milk of Magnesia 30 ml 2 times daily as needed, diclofenac gel 1 % apply 2 g to skin four times daily, famotidine 20 mg once daily as needed, hydrocodone bitartrate and acetaminophen 1 tablet six times daily as needed, ibuprofen 600 mg six times daily as needed, Ma-acetaminophen 325 mg 2 tablets three times daily as needed, Ma-Senna 2 tablets daily as needed, methocarbamol 500 mg four times daily as needed, ondansetron 4 mg three times as needed, polyethylene glycol 3350 17 g twice daily as needed, and sodium chloride 0.9% instill 120 ml into the bladder via catheter to flush once daily. R5's Individualized Medication Management Plan dated February 21, 2024, lacked the following:	01730			

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01730	Continued From page 42 -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On March 5, 2024, at 12:23 p.m., LALD/CNS-D stated the Individualized Medication Management Plan did not contain the required content listed above for R1 and R5 and the plan should have indicated which personnel were allowed to administer the prescribed medications. The licensee's undated Individualized Medication Management Plan and Record policy indicated once a medication management plan was developed, the registered nurse (RN) would develop the resident's medication record with detailed information about the medications staff would be managing. In addition, the medication management plan would include, "a. A statement describing the medication management services that will be provided b. Description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Any resident-specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse	01730			

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01730	Continued From page 43 reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01820 SS=F	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 observation, interview, and record review, the licensee failed to maintain current medication orders for three of three residents (R1, R3, R5). 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 widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 admitted to the licensee on November 29, 2019, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021.	01820			

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01820	Continued From page 44 R1's diagnosis included quadriplegic, attention deficit hyperactive disorder, spinal cord injury at cervical (C) level C1-C4, depression, anxiety, constipation, urinary tract infection, seizure disorder, cystitis (inflammation of the bladder), insomnia, patients noncompliance with other medical treatment and regimen, tobacco use disorder, pressure ulcer wound to right buttock, acute cystitis with hematuria (blood in urine), and chronic suprapubic catheter (urinary drain in the abdomen). R1's MN Service Plan (Waiver) - Addendum to Contract dated October 29, 2019, indicated R1 received assistance with activities, bathing assistance, behavior management, catheter care, dressing, drinking assistance, exercise/passive range of motion, grooming, housekeeping, laundry, meal assistance, medication administration, medication setup, record bowel movement, repositioning, skin care, toileting, and transfer assistance. On March 5, 2024, at 8:24 a.m., the surveyor observed ULP-E administer baclofen 20 milligrams (mg), duloxetine 60 mg, gabapentin 600 mg, metronidazole 500 mg, and amphetamine/dextroamphetamine 25 mg to R1. R1's medication administration record (MAR) dated February 1, 2024, through February 29, 2024, indicated the following medications: amphetamine/dextroamphetamine cap 25 mg extended release (ER) daily, baclofen 20 mg four times daily, duloxetine 60 mg daily, gabapentin 300 mg 2 capsules four times daily, metronidazole 500 mg crush and apply topically (to the skin) with dressing changes, nystatin powder 60 grams (g) twice daily, Butt paste daily,	01820			

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01820	Continued From page 45 acetaminophen six times daily as needed, and bisacodyl 10 mg suppository. The licensee lacked signed provider orders for the medications listed above. R3 R3 admitted to the licensee on October 28, 2019, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R3's diagnosis included quadriplegia C1-C4 neurogenic bowel, neuromuscular dysfunction of bladder cramp and spasms, complete lesion at C4 level of cervical spinal order, depressive disorders, Crohn's disease, orthostatic hypertension, and autonomic dysreflexia. R3's Service Plan (waiver) - Addendum to Contract dated October 29, 2019, indicated R3 received assistance with bathing assistance, catheter care, dressing, drinking assistance, elevate legs, exercise/passive range of motion, grooming, housekeeping, laundry, meal assistance, medication administration, medication setup, ordering supplies, plugging in equipment, repositioning, splints, ted socks, toileting, transfer assistance, and monitoring of blood pressure, output, and temperature. On March 5, 2024, at 7:56 a.m., the surveyor observed ULP-B administer 12 oral pills to R3. R3's MAR dated February 1, 2024, through February 29, 2024, indicated R1 received the following medications; baclofen 10 mg daily, calcium antacid 500 mg daily, cefdinir 300 mg daily, docusate 100 mg daily , Eliquis 5 mg daily, fluoxetine cap 20 mg daily, gabapentin 400 daily,	01820			

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01820	Continued From page 46 oxybutynin 5 mg ER daily, bisacodyl suppository 10 mg daily as needed, fluticasone nasal spray 50 micrograms (mcg) once daily as needed, guaifenesin/dextromethorphan 5 milliliters (ml) six times daily as needed, Nitro-Bid 2 % as needed once daily, Senexon 8.6-50 mg daily, sodium chloride 0.9 percent (%) irrigation for indwelling catheter, trazodone 150 mg daily at bedtime as needed, acetaminophen 325 mg six times daily as needed, and midodrine 5 mg twice daily as needed. R3's After Visit Summary (AVS) dated October 17, 2023, indicated R3 was prescribed the following medications; acetaminophen 325 two tablets four times daily as needed, Eliquis one tablet two times daily, baclofen 10 mg one half tablet two times daily, bisacodyl 10 mg suppository once daily as needed, calcium carbonate 500 mg two times daily, cholecalciferol (vitamin D3) 2000 units once daily, docusate 100 mg once daily, docusate 283 mg/5ml enema into the rectum every day, fluoxetine 2 mg once daily, fluticasone 50 mcg once daily as needed, gabapentin 400 mg 2 capsules three times daily, 0.9% normal saline 2000 ml once weekly or as needed and midodrine 5 mg 2 times daily. The document lacked an electronic or physical signature. R5 R5 admitted to the licensee on April 13, 2023, and began receiving assisted living services. R5's diagnosis included spinal cord injury at thoracic (T) level T1-T6, methamphetamine use disorder severe dependance, antisocial personality disorder, paraplegia, wound of buttock, adjustment disorder with mixed disturbance of emotions and conduct,	01820			

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01820	Continued From page 47 post-traumatic stress disorder, encephalopathy psychosis (brain disease that alters the brain function or structure, perceptions are disrupted and have difficulty in recognizing what is real and what is not), left shoulder pain, substance induced psychosis/substance use disorder, and fractures of the left posterior first and second ribs. R5's Service Plan (Waiver) - Addendum to Contract dated April 13, 2023, indicated R5 received assistance with activities, bathing assistance, behavior management, dressing, drinking assistance, grooming, housekeeping, irrigation/flush of catheter, laundry, meal assistance and preparation, medication administration, medication setup, repositioning, skin care, toileting, transfer assistance, wound care, and monitoring of bowel movement, output, and temperature. R5's MAR dated February 1, 2024, through February 29, 2024, indicated R5 received the following medications: bacitracin ointment apply to catheter daily, atomoxetine 40 mg once daily, baclofen 10 mg three times daily, gabapentin 300 mg three times daily, lurasidone 60 mg half tablet once daily, oxybutynin 10 mg ER once daily, venlafaxine 75 mg ER once daily, Ma-Milk of Magnesia 30 ml 2 times daily as needed, diclofenac gel 1 % apply 2 g to skin four times daily, famotidine 20 mg once daily as needed, hydrocodone bitartrate and acetaminophen 1 tablet six times daily as needed, ibuprofen 600 mg six times daily as needed, Ma-acetaminophen 325 mg 2 tablets three times daily as needed, Ma-Senna 2 tablets daily as needed, methocarbamol 500 mg four times daily as needed, ondansetron 4 mg three times as needed, polyethylene glycol 3350 17 g twice daily as needed, and sodium chloride 0.9% instill 120	01820			

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01820	Continued From page 48 ml into the bladder via catheter to flush once daily. R5's medical record included a document titled Geriton Medical dated May 22, 2023, and included the following medications: sodium chloride 0.9% 250 ml once daily, oxybutynin 10 mg ER 1 tablet once daily, venlafaxine 75 mg 1 capsule once daily, lurasidone one half tablet once daily, atomoxetine capsule 50 mg once daily, pregabalin capsule 50 mg three times daily, baclofen 20 mg three times daily, diclofenac gel 1% apply 2 g topically four times daily, ondansetron 4 mg three times daily, methocarbamol 500 mg one to two tablets four times daily, baclofen 20 mg one half tablet once daily as needed, and cyclobenzaprine 10 mg four times daily. The document lacked an electronic or physical signature. R5's AVS dated February 5, 2024, indicated R5 is prescribed the following medications; atomoxetine 40 mg once daily, bacitracin 500 unit ointment apply to incision, baclofen 10 mg twice daily, collagenase 250 unit ointment apply to wound two or three times a week, cyclobenzaprine 10 mg twice daily, diclofenac 1% gel apply four times daily, famotidine 20 mg twice daily as needed, gabapentin 300 mg three times daily, hydroxyzine 25 mg one to two tablets three times daily, ibuprofen 600 mg four times daily as needed, lurasidone 60 mg one half tablet three times daily, magnesium hydroxide 400 mg/5ml two times daily as needed, methocarbamol 500 mg one to two tablets four times daily as needed, ondansetron 4 mg three times daily, oxybutynin 10 mg once daily, polyethylene glycol 17 g twice daily as needed, sennoside-docusate 8.6-50 mg two tablets two times daily as needed, 0.9% sodium chloride instill 120ml daily or as [patient]	01820			

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01820	Continued From page 49 will allow, and venlafaxine 75 mg once daily. The document lacked an electronic or physical signature. On March 5, 2024, at 10:28 a.m., LALD/CNS-D stated the document titled Geriton Medical was R5's provider orders. On March 6, 2024, at 8:17 a.m., LALD/CNS-D stated the document titled After Visit Summary (AVS) were the medication prescription orders for R1 and R5. The document lacked an electronic or physical signature from a medical prescriber. On March 6, 2024, at 8:18 a.m., LALD/CNS-D stated they were told the documents provided from the resident's pharmacy and AVS were the signed orders. The licensee's undated MN Statute 144G.71, subd 11-14 Medication Prescription and Refills policy indicated the registered nurse (RN) would request a copy of the medication prescription from the prescribing medical doctor or from the pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880			

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01880	Continued From page 50 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. 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 March 4, 2024, at 10:50 a.m., the surveyor observed an unlocked cabinet near the dining room and observed famotidine 20 milligrams (mg), acetaminophen 325, baclofen 20 mg, ibuprofen 600 mg, senna plus 8.5 mg/50 mg, methocarbamol 50 mg, and ondansetron 4 mg for R5 unlocked and unsecured. The surveyor located the lock to the cabinet in a white bin inside of the cabinet. Unlicensed personnel (ULP)-E stated all cabinets that contained medications had locks and they believed it was opened earlier that morning by the overnight staff. Licensed practical nurse/agent (LPN/A)-C stated cabinets should have locks if they contained medications. LPN/A-C stated they normally do not store medications in the cabinet the surveyor found the medication in, and they believed it was moved over the weekend by the ULP. LPN/A-C stated they believed this was an "oversite." On March 5, 2024, at 7:29 a.m., the surveyor	01880			

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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
01880	Continued From page 51 observed an unlocked cabinet different from March 4, 2024, near the dining room and observed famotidine 20 mg, baclofen 20 mg, methocarbamol 500 mg, ondansetron 4mg, midodrine 5 mg, trazodone 75 mg, antacid tablets 1000mg, pain reliever 500 mg for R5. ULP were attending to tasks in R5's room and there was one resident in the common area. On March 5, 2024, 7:42 a.m., the surveyor inquired why the medication cabinet was unlocked and unsecured. ULP-E stated the medication cabinet held emergency medications. ULP-E stated they lock it "sometimes" and no one else can have access to it. The surveyor inquired how no one else would have access to an unlocked medication cabinet in a common area. ULP-E stated, "all of them [residents] are in the wheelchair they cannot reach the area." The surveyor asked the ULP to secure the medication cabinet. ULP-E looked for the lock and asked a coworker for the lock and stated, "I am sorry I am unable to find." R3 R3 was admitted to the licensee for services on October 28, 2019. R3 diagnosis included quadriplegia (cervical) level C1-C4, and complete lesion at C-4 level of cervical spinal cord, depressive disorder, Crohn's disease, orthostatic hypertension (high blood pressure) and autonomic dysreflexia (abnormal, overreaction of the involuntary (autonomic) nervous system to stimulation). R3 Service Addendum (waiver) Plan dated October 28, 2019, indicated R3 received assistance with bathing, catheter care, dressing, drinking assistance, elevating legs,	01880			

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01880	Continued From page 52 exercise/passive range of motion, grooming, housekeeping, laundry, linen exchange, meal assistance, meal preparation, meal reminder, medication assistance, medication administration, medication setup, ordering supplies, plug in equipment, vital signs (VS), repositioning, splints, ted hose, toileting, and transfer assistance. R3's undated medication management indicated only authorized personnel/unlicensed would have access to R3's medications and the medication keys would be secured by staff at all times. In addition, R3 was unable to self-administer medications. On March 5, 2024, at 7:52 a.m., the surveyor observed R3 sitting in wheelchair. ULP-B obtained R3's temperature, walked to the medication lock box mounted on the wall, inserted a key into the lock, and left the room with the key inserted in the medication lock box. On March 5, 2024, at 7:56 a.m., the surveyor observed ULP-B return to R3's room, place gloves on hands, turn the key that was inserted in the medication lock box, remove the pill box container, open the lid labelled "T" and place the content into a medication cup. ULP-B left the medication lock box unsecured for four minutes. On March 5, 2024, at 8:05 a.m., ULP-B stated they had to leave the room to obtain medication cups, and the resident was not able to access the medication lock box because the resident's electric chair was still plugged into the charger. On March 5, 2024, at 8:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the medication lock box should remained locked when staff are not	01880			

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01880	Continued From page 53 present. LALD/CNS-D stated staff were trained to lock the medication lock box when they leave the room. LALD/CNS-D stated, "I don't know why she did that, that is not allowed". The licensees undated Assisted Living Facility (ALF) Policy: Non-Controlled Medication Storage policy indicated medications will be stored in a designated medication storage that is secure and only accessible by authorized staff members. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to discard expired medication for two of four residents (R1, R4). 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 pattern scope (when more than a limited number of residents are affected, more	01890			

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01890	Continued From page 54 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 4, 2024, at 10:50 a.m., the surveyor observed R1's locked medication cabinet which contained MA-Senna-S tablet card expired June 18, 2023. On March 4, 2024, at 10:56 a.m., the surveyor observed R4's locked medication cabinet which contained Polyethylene Glycol 3350 that was in a small plastic basket labeled, "PRN" (as needed). The medication expired on December 5, 2023. On March 4, 2024, at 10:56 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the expired medications should have been removed from the cabinet but they did not remove the medication because the resident was not taking the medication. The licensee's undated Assisted Living Facility: Non-Controlled Medication Storage policy indicated that expired medication would be removed from the storage area and disposed of properly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	01910			

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01910	Continued From page 55 resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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	01910			

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01910	Continued From page 56 only occasionally). The findings include: R2 was discharged from the licensee on September 26, 2023. R2's diagnoses lymphedema, hypertension, major depressive disorder, obstructive sleep apnea, chronic kidney disease, schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), anxiety disorder, and morbid obesity. R2's Discharge Summary dated September 26, 2023, indicated R2 was deceased, and the licensee provided medication management. R2's medication disposition log included the following medications: carvedilol 12.5 milligrams (mg) 30 tablets, daily-vit tab nine tablets, tamsulosin cap 0.4 mg two tablets, spironolactone 25 mg two tablets, pantoprazole 20 mg 11 tablets, clozapine 200 mg 5 tablets, acetaminophen 500 mg three tablets, atorvastatin 10 mg two tablets, topiramate 50 mg two tablets, lisinopril 20 mg 30 tablets disposed of on October 5, 2023, by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D and an unidentified staff member. On March 4, 2024, at 11:22 a.m., the surveyor observed a locked metal medication box on the wall of room two. The metal box had a locking mechanism on the outside and a small hole on the top. The surveyor observed a plastic medication set up box that contained at least one unknown orange pill located within the metal medication box. Licensed practical nurse/agent	01910			

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01910	Continued From page 57 (LPN/A)-C attempted to locate key for the medication box and stated they were unable to find it. The surveyor inquired why they did not have a key to the medication box. LPN/A-C stated they had an extra key, but the resident left a while ago and they moved everything. On March 4, 2024, at 11:35 a.m., LPN/A-C stated they were unable to find the key, so they were going to have to replace the whole box. LPN/A-C stated the resident moved out in September or October of 2023. The surveyor inquired if there was any medication left in the medication box. LPN/A-C stated, "I doubt it." The surveyor showed LPN/A-C the pill located in the metal box through the hole on the top of the box. The surveyor inquired why the medication was still in the box. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated "we should have removed it." LALD/CNS-D stated they were responsible for medication disposal and other licensed nurses assisted them. LPN/A-C stated the licensee completed medication disposition on discharged residents and it was an "oversight on my part." The licensee's undated Medication Disposition or Disposal policy indicated the licensee would develop policies to be followed in disposing of medication that are no longer used or after the resident has been discharged or died. Medications to be disposed of would be listed, counted, and the person disposing of the medications would sign the note/form. The documentation of the disposal would be located in the record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01910			

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01910	Continued From page 58 days	01910			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01940			

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01940	Continued From page 59 licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1, R5) who received treatments. 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 widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on November 29, 2019, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R1's diagnosis included quadriplegic, attention deficit hyperactive disorder, spinal cord injury at cervical (C) level C1-C4, depression, anxiety, constipation, urinary tract infection, seizure disorder, cystitis (inflammation of the bladder), insomnia, patients noncompliance with other medical treatment and regimen, tobacco use disorder, pressure ulcer wound to right buttock, acute cystitis with hematuria (blood in urine), and chronic suprapubic catheter (urinary drain in the abdomen). R1's MN Service Plan (Waiver) - Addendum to Contract dated October 29, 2019, indicated R1 received assistance with activities, bathing assistance, behavior management, catheter care, dressing, drinking assistance, exercise/passive range of motion, grooming, housekeeping,	01940			

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01940	Continued From page 60 laundry, meal assistance, medication administration, medication setup, record bowel movement, repositioning, skin care, toileting, and transfer assistance. R1's record included a document titled ACH Advanced Comfort Health dated March 5, 2024, that indicated R1 had a wound on the sacrum/buttock and left gluteus and received wound care on the following days: -Tuesday clean the entire wound with a wound cleanser and pat dry. Primary dressing: Place Calcium Alginate, abdominal pad (ABD) and secure with Kerlix gauze and tape; -Thursday advance wound care: The nurse practitioner (NP) will see the [resident] for a weekly debridement, and; -Saturday dressing change clean the peri-wound area (around the wound) with a wound cleanser without cleaning the wound bed. Leave the Adaptic dressing in place (only change Adaptic if saturated). Dressing sequence; place Calcium Alginate, ABD pad and secure with kerlix gauze and tape. R1's Assessment dated January 20, 2024, lacked assessment of wounds and wound treatments. R1's Medication Administration Record (MAR) and Treatment Administration Record dated February 1, 2024, through February 29, 2024, lacked documentation of wound care. R1's treatment management plan comprised of multiple records lacked the following content: - statement of the types of services that will be provided. - documentation of specific resident instructions relating to the treatments or therapy's administration;	01940			

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01940	Continued From page 61 - identification of treatment of therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administrated as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when they are any changes. R5 R5 admitted to the licensee on April 13, 2023, and began receiving assisted living services. R5's diagnosis included spinal cord injury at thoracic (T) level T1-T6, methamphetamine use disorder severe dependance, antisocial personality disorder, paraplegia, wound of buttock, adjustment disorder with mixed disturbance of emotions and conduct, post-traumatic stress disorder, encephalopathy psychosis (brain disease that alters the brain function or structure, perceptions are disrupted and have difficulty in recognizing what is real and what is not), left shoulder pain, substance induced psychosis/substance use disorder, and fractures of the left posterior first and second ribs. R5's Service Plan (Waiver) - Addendum to Contract dated April 13, 2023, indicated R5 received assistance with activities, bathing assistance, behavior management, dressing, drinking assistance, grooming, housekeeping, irrigation/flush of catheter, laundry, meal	01940			

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01940	Continued From page 62 assistance and preparation, medication administration, medication setup, repositioning, skin care, toileting, transfer assistance, wound care, and monitoring of bowel movement, output, and temperature. R5's record included a document titled ACH Advanced Comfort Health dated March 5, 2024, that indicated R5 had wound care to left heel, lateral (side) right lower foot, lateral left upper foot, and lateral left shin on the following days: -Tuesday clean the entire wound with a wound cleanser and pat dry. Primary dressing: Place Calcium Alginate, abdominal pad (ABD) and secure with Kerlix gauze and tape; -Thursday advance wound care: The nurse practitioner (NP) will see the [resident] for a weekly debridement; and -Saturday dressing change clean the peri-wound area (around the wound) with a wound cleanser without cleaning the wound bed. Leave the Adaptic dressing in place (only change Adaptic if saturated). Dressing sequence; place Calcium Alginate, ABD pad and secure with kerlix gauze and tape. R5's Assessment dated January 19, 2024, indicated R5 had a wound on at the coccyx (tail bone) that measured 15 centimeters (cm) length by 5 cm width by 4 cm deep, wound care is performed by an outside agency wound care nurse, and the resident had two wound vacs (draining system for the wound). On March 5, 2024, at 7:25 a.m., R5 declined to be observed by surveyors. R5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated February 1, 2024, through February 29,	01940			

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01940	Continued From page 63 2024, lacked documentation of wound care. R5's individualized treatment plan comprised of multiple documents lacked the following content: -documentation of specific resident instructions relating to the treatments or therapy's administration; -identification of treatment of therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administrated as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when they are any changes. On March 6, 2024, at 11:38 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated ULP were trained to perform wet to dry dressing (using saline soaked gauze, placing it in the wound for it to dry) if a resident's dressing became visibly soiled and then would report the licensee's nurse. LALD/CNS-C stated the licensee's licensed nurse would then come into the facility change the wet to dry dressing to the prescribed treatment. LALD/CNS-C stated the agency would continue their scheduled treatments with the resident. The licensee's undated policy titled MN Statute: 144G.71 Subd 7. Delegation of Nursing Tasks/Therapy Tasks indicated an assessment is required by a registered nurse (RN) and prior of	01940			

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01940	Continued From page 64 any delegated nursing/therapy tasks, a RN/therapist would assess the individual who needs nursing care, the environment or condition of the setting and the skill of the unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure it had orders for treatments for two of four residents (R1, R5) who received treatments. 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 widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6264 SUNRISE TERRACE BROOKLYN PARK, MN 55428		
(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
01970	Continued From page 65 The findings include: R1 admitted to the licensee on November 29, 2019, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R1's diagnosis included quadriplegic, attention deficit hyperactive disorder, spinal cord injury at cervical (C) level C1-C4, depression, anxiety, constipation, urinary tract infection, seizure disorder, cystitis (inflammation of the bladder), insomnia, patients noncompliance with other medical treatment and regimen, tobacco use disorder, pressure ulcer wound to right buttock, acute cystitis with hematuria (blood in urine), and chronic suprapubic catheter (urinary drain in the abdomen). R1's MN Service Plan (Waiver) - Addendum to Contract dated October 29, 2019, indicated R1 received assistance with activities, bathing assistance, behavior management, catheter care, dressing, drinking assistance, exercise/passive range of motion, grooming, housekeeping, laundry, meal assistance, medication administration, medication setup, record bowel movement, repositioning, skin care, toileting, and transfer assistance. R1's Assessment dated January 20, 2024, lacked assessment of wounds and wound treatments. R1's record included a document titled ACH Advanced Comfort Health dated March 5, 2024, that indicated R1 had a wound on the sacrum/buttock and left gluteus and received wound care on the following days: -Tuesday clean the entire wound with a wound	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6264 SUNRISE TERRACE BROOKLYN PARK, MN 55428		
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01970	Continued From page 66 cleanser and pat dry. Primary dressing: Place Calcium Alginate, abdominal pad (ABD) and secure with Kerlix gauze and tape; -Thursday advance wound care: The nurse practitioner (NP) will see the [resident] for a weekly debridement, and; -Saturday dressing change clean the peri-wound area (around the wound) with a wound cleanser without cleaning the wound bed. Leave the Adaptic dressing in place (only change Adaptic if saturated). Dressing sequence; place Calcium Alginate, ABD pad and secure with kerlix gauze and tape. R1's medical record lacked a signed provider's treatment order for as needed (PRN) wound care. On March 4, 2024, at 2:17 p.m., R1 stated they had a wound that was cared for by an outside agency unless the agency was unavailable then the licensee would assist with wound care. R5 R5 admitted to the licensee on April 13, 2023, and began receiving assisted living services. R5's diagnosis included spinal cord injury at thoracic (T) level T1-T6, methamphetamine use disorder severe dependance, antisocial personality disorder, paraplegia, wound of buttock, adjustment disorder with mixed disturbance of emotions and conduct, post-traumatic stress disorder, encephalopathy psychosis (brain disease that alters the brain function or structure, perceptions are disrupted and have difficulty in recognizing what is real and what is not), left shoulder pain, substance induced psychosis/substance use disorder, and fractures of the left posterior first and second ribs.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6264 SUNRISE TERRACE BROOKLYN PARK, MN 55428		
(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	
01970	Continued From page 67 R5's Service Plan (Waiver) - Addendum to Contract dated April 13, 2023, indicated R5 received assistance with activities, bathing assistance, behavior management, dressing, drinking assistance, grooming, housekeeping, irrigation/flush of catheter, laundry, meal assistance and preparation, medication administration, medication setup, repositioning, skin care, toileting, transfer assistance, wound care, and monitoring of bowel movement, output, and temperature. R5's Assessment dated January 19, 2024, indicated R5 had a wound on at the coccyx (tail bone) that measured 15 centimeters (cm) length x 5 cm width x 4 cm deep, wound care is performed by an outside agency wound care nurse, and the resident had two wound vacs (draining system for the wound). R5's record included a document titled ACH Advanced Comfort Health dated March 5, 2024, that indicated R5 had wound care to left heel, lateral (side) right lower foot, lateral left upper foot, and lateral left shin on the following days: -Tuesday clean the entire wound with a wound cleanser and pat dry. Primary dressing: Place Calcium Alginate, ABD and secure with Kerlix gauze and tape; -Thursday advance wound care: The nurse practitioner (NP) will see the [R5] for a weekly debridement, and; -Saturday dressing change clean the peri-wound area (around the wound) with a wound cleanser without cleaning the wound bed. Leave the Adaptic dressing in place (only change Adaptic if saturated). Dressing sequence; place Calcium Alginate, ABD pad and secure with kerlix gauze and tape.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6264 SUNRISE TERRACE BROOKLYN PARK, MN 55428		
(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
01970	Continued From page 68 R5's medical record lacked a signed provider's treatment order for PRN wound care. On March 5, 2024, at 7:25 a.m., R5 declined to be observed by surveyors. On March 6, 2024, at 11:38 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated ULPs were trained to perform wet to dry dressing (using saline soaked gauze, placing it in the wound for it to dry) if a resident's dressing became visibly soiled and then would report the facility nurse. LALD/CNS-C stated the licensee's licensed nurse would then come into the facility change the wet to dry dressing to the prescribed treatment. LALD/CNS-C stated the outside agency would continue their scheduled treatments with the resident. LALD/CNS-C stated they would document the PRN dressing changes in the resident's progress notes. The licensee's undated policy titled MN Statute: 144G.71 Subd 7. Delegation of Nursing Tasks/Therapy Tasks indicated an assessment is required by a registered nurse (RN) and prior of any delegated nursing/therapy tasks, a RN/therapist would assess the individual who needs nursing care, the environment or condition of the setting and the skill of the unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6264 SUNRISE TERRACE BROOKLYN PARK, MN 55428			
(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 69 (a) Residents have the right to care and assisted 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 ensure medical oxygen tanks secured stored properly in noncombustible racks to prevent injury to all residents who resided in the assisted living facility. 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 widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 4, 2024, at 11:32 a.m., during a facility tour of the two-level house, the surveyor observed a single unsecured oxygen tank standing upright in the closet of unlocked room two which was unoccupied. The oxygen tank lacked proper storage security. On March 4, 2024, at 11:38 a.m., LALD/CNS-D stated the oxygen tank was delivered without a cylinder cart or stand. LALD/CNS-D stated oxygen tanks should be stored in a cylinder cart and nurses were responsible for ensuring oxygen	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER MN BEST HOMECARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6264 SUNRISE TERRACE BROOKLYN PARK, MN 55428			
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02310	Continued From page 70 tanks are stored correctly. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, recommends oxygen tanks be secured with racks or by chains. The licensee's undated Safe Oxygen use and Storage policy indicated oxygen containers must be secured in a stand or cart so they cannot be knocked over while in use or in storage. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			



Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: 03/04/24
Time: 11:14:49
Report: 7994241047

Food and Beverage Establishment Inspection Report

Page 1

Location:

Mn Best Homecarellc
6264 Sunrise Terrace
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0039363
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128065003
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B **** Priority 1 ****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISHWASHER WAS RECENTLY REPLACED WITH A NON SANITIZING DISHWASHER. PROVIDE AN APPROVED DISHWASHER AND SUPPLY INSPECTOR WITH PICTURE AND SPECIFICATION SHEET.

Comply By: 03/04/24

4-300 Equipment Numbers and Capacities

4-302.13A **** Priority 2 ****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

CURRENT THERMOMETER WAS FOUND NOT WORKING. SPOKE WITH MANAGER ABOUT VARIOUS OPTIONS FOR TESTING DISHWASHER.

Comply By: 03/04/24

2-100 Supervision

2-102.12AMN

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

CURRENT CFPM SPLITS TIME BETWEEN MULTIPLE HOUSES. PROVIDE A CFPM FOR EACH HOUSE.

Comply By: 03/04/24

Type: Full
Date: 03/04/24
Time: 11:14:49
Report: 7994241047
Mn Best Homecarellc

Food and Beverage Establishment Inspection Report

Page 2

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

dishwasher and strips

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

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND SMOOTH PAINTED 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.

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 7994241047 of 03/04/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Signed: _____

Establishment Representative

Signed:  _____

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

Report #: 7994241047		Food Establishment Inspection Report													
m DEPARTMENT OF HEALTH Minnesota Department of Health 625 Robert Street North St Paul		No. of RF/PHI Categories Out				2		Date 03/04/24							
		No. of Repeat RF/PHI Categories Out				0		Time In 11:14:49							
		Legal Authority MN Rules Chapter 4626						Time Out							
Mn Best Homecarellc		Address 6264 Sunrise Terrace			City/State Brooklyn Park, MN			Zip Code 55428		Telephone 6128065003					
License/Permit # 0039363		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		Compliance Status				COS		R	
Supervision															
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											
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						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 labeled; 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											
Food Recalls:															
Person in Charge (Signature)															
Date: 03/04/24															
Inspector (Signature)															