Electronically Delivered

January 2, 2025

Licensee
First Mercy Homes LLC
7420 17th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL36983015

Dear Licensee:

On November 25, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 5, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

October 10, 2024

Licensee
First Mercy Homes LLC
7420 17th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL36983015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 5, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

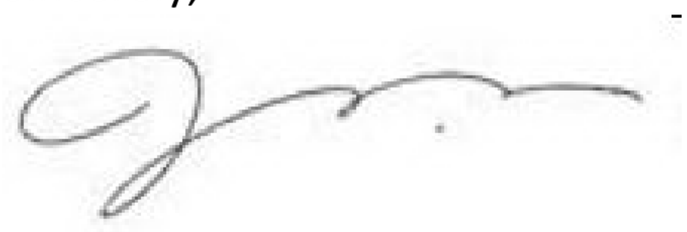
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36983	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

(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: SL36983015-0 On September 3, 2024, through September 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record (DOR) for the licensee. This had the potential to affect all the licensee's 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: On September 3, 2024, at 10:40 a.m., during the entrance conference, the surveyor reviewed the Board of Executives for Long-term Services and Supports (BELTSS) website with licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B. LALD/RN-A's license was current but the DOR for the licensee was expired as of October 23, 2023. Also, LALD-A/RN stated she was not aware of the assisted living license requirement to be identified as DOR for the licensee in the BELTSS website for the licensee. On September 4, 2024, at 11:30 a.m., the	0 110		

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0 110	Continued From page 2 surveyor checked the BELTSS website and LALD-A/RN remained expired as the DOR for the licensee. The surveyor showed LALD/RN-A on the BELTSS website where the DOR information would be listed once corrected. In addition, LALD/RN-A verbalized she planned to update the DOR in the BELTSS website. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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;	0 470		

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0 470	Continued From page 3 (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staffing plan was posted as required, potentially affecting the four residents 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 3, 2024, at 9:58 a.m., the surveyor observed the main areas of the facility with licensed assisted living director/registered nurse (LALD/RN)-A. The surveyor observed a posted "[Licensee] Staff Schedule August 2024" outside the kitchen area in the main living room of the facility dated August 5, 2024, through August 18, 2024, which included employee names, shift schedule, and days of the week. The weekly schedule posted was not current to date. On September 3, 2024, at 10:05 a.m., LALD/RN-A stated the staff schedule posted at the facility was not a current daily staffing schedule and LALD/RN-A verbalized she planned	0 470		

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0 470	Continued From page 4 to ensure the daily schedule was updated and posted. On September 3, 2024, at 11:55 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration to one of the licensee's residents. On September 5, 2024, at 2:00 p.m., LALD/RN-A and CNS-B stated the licensee would ensure a current and accurate staff schedule was always posted in the main area of the facility. The licensee's Staffing policy dated January 13, 2023, included 6. A daily staffing schedule is prepared by the clinical nurse supervisor and addresses: -Home health aide work schedules for each home health aide showing all work shifts with days/hours worked; and -The home health aide's resident assignments or work location. Also, indicated "7. The schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public." 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,	0 480		

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0 480	Continued From page 5 chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 3, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact	0 550		

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0 550	Continued From page 6 information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure, the name, and the telephone numbers for the individuals who are responsible for handling resident grievances. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 3, 2024, at 9:58 a.m., the surveyor observed the common areas shared by residents, staff, and visitors. The licensee's 2.10 Complaint / Grievance Posting policy was posted but lacked the required licensee's information to include the name, telephone number, and email contact	0 550		

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0 550	Continued From page 7 information for the individuals who were responsible for handling resident grievances. On September 3, 2024, at 11:26 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated "yes," I see the posting was missing some of required content. Also, LALD-A verbalized this document needed to be updated. On September 5, 2024, at 2:00 p.m., during the exit conference, LALD/RN-A verbalized she planned to update the grievance procedure posted in the main with the required contact information. The licensee's Grievance policy dated January 13, 2023, indicated "2. A copy of the grievance procedure is conspicuously posted in the residence with the following information: -Name, phone number and email contact information for the individuals who are responsible for handling resident complaints." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 8 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all the required components included in Appendix Z. This had the potential to affect all residents, staff, and visitors during an emergency. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 4, 2024, at 9:50 a.m., the surveyor requested to review the licensee's emergency	0 680		

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0 680	Continued From page 9 preparedness plan. Clinical nurse supervisor (CNS)-B provided a three-ring binder that included emergency policies and procedures. The licensee's EPP dated 2022, did not include the following required content: -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; -documentation of a hazards risk assessment; -missing resident policy reviewed quarterly; -policy that addresses substinence needs for staff and residents; -develop a system to track the location of on-duty staff and sheltered residents; -develop a process to address safe evacuation from the facility, including consideration of care needs of evacuees; staff responsibilities; transportation; identification of evacuation location; -development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; and -participation in a full-scale community based exercise. On September 3, 2024, at 10:15 a.m., licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B verbalized the licensee utilized an EPP template provided to them by a consultant to create the facility EPP. LALD/RN-A and CNS-B confirmed the licensee was familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS]. LALD/RN-A stated the	0 680		

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0 680	Continued From page 10 licensee had been working on the Emergency Preparedness binder had not yet incorporated all the required components of Appendix Z. Finally, LALD/RN verbalized she planned to update the EPP plan to include all the required contents. The licensee's Emergency Preparedness policy, dated January 13, 2023, indicated "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required monthly	0 790		

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0 790	Continued From page 11 maintenance on fire extinguishers as required for the facility. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On September 5, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director/registered nurse (LALD/RN)-A and clinical nursing supervisor (CNS)-B. During the facility tour, it was observed portable fire extinguishers were tagged, showing the required annual service but lacked records to show the required monthly visual inspections were performed or recorded for all portable fire extinguishers throughout buildings. During the facility tour, CNS-B verified the required monthly visual inspections were not performed for portable fire extinguishers. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

(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
0 800	Continued From page 12 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: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 5, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director/registered nurse (LALD/RN)-A and clinical nursing supervisor (CNS)-B. During the facility tour, survey staff observed the following items: In the bathroom on the main level, it was observed the wall plaster was bubbled, and the wall paint was cracked with evidence of water damage. In the kitchen on the main level, it was observed that the wood corner trim was removed from the	0 800		

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0 800	Continued From page 13 wall, and the nails were exposed, which were hazards to residents. In resident room 2 on the main level, the window insect screen frame was found to be broken, and the screen was ripped. In the back yard by the detached garage, it was observed that burnt, used cigarettes were being disposed of on the ground, without a proper disposal container, creating a possible fire hazard. In the office on the lower level, it was observed that the ceiling plaster was bubbled, and the ceiling had brown stains with evidence of water damage. In resident bedroom 4 on the lower level, it was observed that the egress window was obstructed by a tree growing in the window well, and the tree obstructed the egress window from opening fully. During the facility tour, CNS-B confirmed the facility was not in good repair in regard to resident health and safety in accordance with the maintenance and repair program and verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 14 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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors.	0 810		

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0 810	Continued From page 15 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 September 5, 2024, at 11:30 a.m., the licensed assisted living director/registered nurse (LALD/RN)-A and clinical nursing supervisor (CNS)-B provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP also instructed staff to close all doors to contain the fire, but the facility did not have a fire rated door and wall assembly. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar	0 810		

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0 810	Continued From page 16 emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on September 5, 2024, at 12:00 p.m., CNS-B stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. CNS-B also confirmed that the facility had not developed the necessary fire protection procedures for residents. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on September 5, 2024, at 12:00 p.m., CNS-B stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. CNS-B confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. Provided documentation indicated that	0 810		

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0 810	Continued From page 17 the drills were conducted on 7/5/24, 1/20/24, 5/15/23, 11/17/23, and 9/15/23, with no further drills being documented for the year. Provided documentation indicated drills were conducted for the morning and afternoon shifts, but the facility failed to provide two drills for the night shift. During the interview on September 5, 2024, at 12:00 p.m., CNS-B confirmed that the licensee did not conduct evacuation drills every other month and confirmed that the facility did not conduct two drills for the night shift. CNS-B verified there were no further documented drills for the facility for the year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 820		

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0 820	Continued From page 18 failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the resident in bedroom 2 on the main level. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 5, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director/registered nurse (LALD/RN)-A and clinical nursing supervisor (CNS)-B. During the facility tour, survey staff observed the following items: It was observed that unoccupied resident bedroom 2 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 18 inches in height and 23 inches in width, with a total openable area of 414 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable	0 820		

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0 820	Continued From page 19 area (4.5 square feet) for the window. During the facility tour, survey staff explained to CNS-B that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. CNS-B acknowledged the above finding. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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01370	Continued From page 20 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training was completed for all required skill areas, prior to providing services, for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On September 3, 2024, at 11:55 a.m., the surveyor observed ULP-C assist R2 with medication administration. ULP-C was hired on June 6, 2024, to provide	01370		

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01370	Continued From page 21 direct care services to residents. ULP-C's employee record lacked evidence of the following training: -standby assistance techniques and how to perform them; and -awareness of commonly used health technology equipment and assistive devices. On September 4, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated he would check to see if ULP-C's employee record or online training transcript showed evidence of this training being completed. On September 4, 2024, at 1:17 p.m., the licensee provided the surveyor with ULP-C's training documents, via email, for standby assistance and awareness of commonly used health technology equipment, dated September 4, 2024, while the survey was in process. On September 4, 2024, at 11:51 p.m., the licensee stated, via email, "After reviewing our records, we learned the staff in question was in fact missing the identified training modules. We quickly assigned them to her, and she completed them immediately. For accuracy and transparency, the forms reflect the actual date of the client's training." On September 5, 2024, at 2:00 p.m., during the exit conference, licensed assisted living director/registered nurse (LALD/RN)-A also verbalized ULP-C was missing some of the required orientation training content and she planned to get this training assigned to ULP-C. The licensee's Staff Competency policy dated January 13, 2023, included 3. Training and	01370		

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01370	Continued From page 22 competency evaluations for all unlicensed personnel include the following. Refer to the Competency Manual for criteria. Unlicensed personnel may not work for [Licensee] until they have successfully passed the written (at 80%) and demonstration competency evaluation. a. Documentation requirements for all services provided; b. Reports of changes in the resident's condition to the supervisor designated by the assisted living provider; c. Basic infection control, including blood-borne pathogens; d. Maintenance of a clean and safe environment; e. Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; f. Training on the prevention of falls for providers working with the elderly or those at risk of falls; g. Standby assistance techniques and how to perform them; h. Medication, exercise, and treatment reminders; i. Basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating; j. Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; k. Awareness of confidentiality and privacy; l. Understanding appropriate boundaries between staff, residents, and the resident's family; m. Procedures to utilize in handling various emergency situations; and n. Awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01380		

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01380	Continued From page 24 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: On September 3, 2024, at 11:55 a.m., the surveyor observed ULP-C assist R2 with medication administration. ULP-C was hired on June 6, 2024, to provide direct care services to residents. ULP-C's employee record lacked evidence of the following training and competency evaluations: -safe transfer techniques and ambulation; and -range of motioning and positioning. On September 4, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated he would check to see if ULP-C's employee record or online training transcript showed evidence of this training being completed. On September 4, 2024, at 1:17 p.m., the licensee provided the surveyor with ULP-C's training documents, via email, for standby assistance and awareness of commonly used health technology equipment, dated September 4, 2024, while the survey was in process. On September 4, 2024, at 11:51 p.m., the licensee stated, via email, "After reviewing our records, we learned the staff in question was in fact missing the identified training modules. We quickly assigned them to her, and she completed them immediately. For accuracy and transparency, the forms reflect the actual date of	01380		

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01380	Continued From page 25 the client's training." On September 5, 2024, at 2:00 p.m., during the exit conference, licensed assisted living director/registered nurse (LALD/RN)-A verbalized ULP-C was missing some of the required orientation training content and she planned to get this training assigned to ULP-C. The licensee's Staff Competency policy dated January 13, 2023, included 4. Home Health Aides (HHA) providing assisted living services and who have not completed a state-approved formal training and competency evaluation program will demonstrate competency through the following process. a. Satisfactory completion of an oral or written test on the tasks the HHA will perform. Refer to the Competency Manual for criteria. b. Horne Health Aides may not work for [Licensee] until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following: i. Observation, reporting and documenting of resident status; ii. Basic knowledge of body functioning and changes in body function, injuries, or other reportable changes; iii. Recognizing physical, emotional, cognitive and development needs of the resident; iv. Basic infection control, including blood-borne pathogens; v. Maintenance of a clean and safe environment; vi. Falls prevention; vii. Safe transfer techniques and ambulation; viii. Range of motion and positioning; ix. Administering medications or treatments as required; x. Basic nutrition, meal preparation, food safety and assistance with eating; xi. Preparation of modified diets;	01380		

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FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

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01380	Continued From page 26 xii. Communication skills and barriers; xiii. Cultural diversity; xiv. Confidentiality/privacy; xv. Professional boundaries; xvi. Handling of emergencies; and xvii. Commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36983	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

(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
01620	Continued From page 27 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an ongoing resident monitoring and reassessment no more than 14 days after admission for one of two residents (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 only occasionally). The findings include: On September 3, 2024, at 10:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee completed assessments upon admission, at 14 days, every 90 days, and with changes in condition. On September 3, 2024, at 11:55 a.m., the surveyor observed ULP-C assist R2 with medication administration. R2 was admitted January 5, 2024, and had diagnoses including schizoaffective with manic tendencies (a mental health and mood disorder), post-traumatic stress disorder (a mental health disorder that develops following a traumatic event), and substance abuse disorder. R2's service plan dated July 27, 2024, indicated	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36983	A. BUILDING: _____ B. WING _____	09/05/2024

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01620	Continued From page 28 R2 received services including assistance with housekeeping, meals, laundry, behavior management, vital signs, and medication administration. R2's medical record included an initial comprehensive nursing assessment dated January 5, 2024, and subsequent assessment completed on January 23, 2024, 18 days after the initial assessment was completed. On September 4, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated there was another nurse employed during the time of R2's 14-day assessment and CNS-B would review R2's progress notes in the electronic medical record to see if there was a reason why the 14-assessment was late. Also, CNS-B verbalized sometimes the resident may be away for the weekend which may have caused the lateness of the 14-day assessment. On September 5, 2024, at 2:00 p.m., during the exit conference, the surveyor provided information to licensed assisted living director/registered nurse (LALD/RN)-A and CNS-B on the 14-day comprehensive nursing assessment requirement of being completed no more than 14 days from the resident's initial nursing assessment. Also, CNS-B verbalized the licensee would ensure the 14-day nursing assessments were completed within the required timeframe. The licensee's Assessment and Reassessment policy dated January 13, 2023, included "7. The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services."	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 29 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/03/24*
Time: 22:30:29
Report: 1050241173

Food and Beverage Establishment Inspection Report

Location:
First Mercy Homes Llc
7420 17th Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0037789
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2069153015
ID #:

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

The following orders were issued during this inspection.

2-500 Responding to contamination events

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

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

FACILITY DID NOT HAVE A KIT AVAILABLE ON SITE DURING THE TIME OF INSPECTION. DISCUSSED THE IMPORTANCE AND PROVIDED MDH FACT SHEETS. COMPLY WITH RULE ABOVE.

Comply By: 09/03/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER KEPT ON SITE. ESTABLISHMENT COOKS THIN FOODS/MEATS. OPERATOR PURCHASED BRAND NEW ONE FOR EMPLOYEES TO USE 9/4/24.

Comply By: 09/03/24

4-200 Equipment Design and Construction

4-204.112A

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

OBSERVED THERE WAS NOT A SECONDARY THERMOMETER LOCATED IN REFRIGERATOR LOCATED IN LIVING ROOM. DISCUSSED REQUIREMENTS AND REASON WHY ITS NEEDED.

Type: Full
Date: *09/03/24*
Time: 22:30:29
Report: 1050241173
First Mercy Homes Llc

Food and Beverage Establishment Inspection Report

OPERATOR PURCHASED NEW AND PLACED INSIDE 9/4/24.
Comply By: 09/03/24

Food and Equipment Temperatures

Process/Item: Cold Holding/Milk
Temperature: 39F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Cheese
Temperature: 40F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Lettuce
Temperature: 40F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Carrots
Temperature: 41F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

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

Inspection was completed with Abdirahman Hassan and Director Fonzia. Dede Hinnendael was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection. Meals are prepared on site and groceries are bought by staff.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets and tile flooring. All found to be in good condition. Currently facility has two refrigerators in use both have secondary thermometers.

Floors were updated in 2022 and changed to Vinyl plank all found to be in good condition.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

Type: Full
Date: *09/03/24*
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First Mercy Homes Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department Of Health inspection report number 1050241173 of 09/03/24.

Certified Food Protection Manager: Fonzia A. Omar

Certification Number: FM1114293 Expires: 10/14/25

Inspection report reviewed with person in charge and emailed.

Signed:_____

Fonzia A. Omar
Operator

Signed:_____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us