



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 14, 2023

Licensee
Inspire Care Inc
610 Silver Lake Road Northwest
New Brighton, MN 55112

RE: Project Number(s) SL37310015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 29, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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: SL37310015 On November 27, 2023, through November 29, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two active residents; both receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112			
(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
0 480	Continued From page 1 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 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 November 28, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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
0 630	Continued From page 2 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) included specific measures to be taken to minimize the risk of abuse for one of 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's IAPP dated October 6, 2023, did not include specific measures to be taken to minimize the risk of abuse. On November 29, 2023, at 11:50 a.m., clinical nurse supervisor (CNS)-B stated interventions to minimize the risk of abuse were missing from R1's IAPP. CNS-B further stated she was aware of the requirement but did not write it on the plan. The licensee's undated Abuse Prevention Plan policy indicated all residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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
0 630	Continued From page 3 vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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
0 810	Continued From page 4 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. 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 November 28, at 12:00 p.m., licensed assisted living director (LALD)-A provided documenatation on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112			
(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
0 810	Continued From page 5 Record review of the available documentation indicated the licensee did not maintain the fire safety and evacuation plan (FSEP) for the facility. The FSEP contained the following discrepancies: The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. The facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. The FSEP indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on November 28, at 12:00 p.m., LALD-A stated the facility provided only one fire safety training in new hire orientation and confirmed this deficiency. DRILLS Record review of the available documentation	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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
0 810	Continued From page 6 indicated the licensee did not conduct evacuation drills twice per year per shift as required by statute. Provided documentation indicated drills were conducted on 3/7/23 at 10:00 a.m., 5/20/23 at 8:10 a.m., 7/19/23 at 11:00 a.m., and 9/20/23 at 9:30 a.m. The licensee conducted drills on the first shift only and failed to provide two drills on the second shift and the third shift. During the interview on November 28, at 12:00 p.m., LALD-A verified there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01300 SS=D	144G.60 Subd. 2 Qualifications, training, and competency All staff persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs; and promote and be trained to support the assisted living bill of rights. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the administration of client medications by unlicensed personnel (ULP) followed acceptable standards for one of one employee (ULP-C). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to	01300			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112			
(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
01300	Continued From page 7 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a hire date of May 4, 2023, and provided direct assisted living services, including medication administration, to the licensee's residents. On November 28, 2023, at 11:55 a.m., the surveyor observed ULP-C administer medications to R2. ULP-C performed hand hygiene tore off the noon pouch of pills from the strip of packaged medications and gave the medication to the resident. ULP-C failed to reference or compare the medication given to the resident's electronic medication administration record (EMAR). On November 29, 2023, at 11:15 a.m., ULP-C stated when the registered nurse (RN) trained him on medication administration he was trained to compare the medications to the EMAR, and he had to demonstrate to the nurse that he knew what he was doing. ULP-C further stated he usually does compare the medications to the EMAR before giving them, but he was just nervous being watched by the surveyor. ULP-C's employee record indicated he had been trained on medication administration and passed a competency evaluation upon hire. On November 29, 2023, at 12:40 p.m., clinical nurse supervisor (CNS)-B stated all staff had been trained and had to demonstrate competency for medication administration including verifying medication with the EMAR before administering	01300			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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
01300	Continued From page 8 them. The licensee's undated Qualification, Training, and Competency policy indicated all staff members must be competent in the provision of services consistent with current practice standards appropriate to the resident's need and support the assisted living bill of rights. Facility shall implement and provide a competency evaluation program that meets the minimum standards in accordance with state guidelines. No further information was provided. Time period for correction: Seven (7) days.	01300			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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
01440	Continued From page 9 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the residents). The findings include: ULP-C had a hire date of May 4, 2023. ULP-C's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The document in ULP-C's record titles Supervision of Home Health Aide was dated May 4, 2023, the same day as his hire and training date. On November 28, 2023, at 11:55 a.m., the surveyor observed ULP-C performing medication administration for R2.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112			
(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
01440	Continued From page 10 On November 29, 2023, at 11:50 a.m., licensed assisted living director (LALD)-A stated the clinical nurse supervisor (CNS)-B checked him off for R2 upon hire and then when R1 moved in on September 25, 2023, she watched him again. On November 29, 2023, at 12:40 p.m., CNS-B stated ULP-C's 30-day supervision did not meet requirements. The licensee's undated Supervision of Unlicensed Personnel policy indicated the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs delegated tasks for residents, and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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 11 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) used the uniform assessment tool for ongoing assessments and monitoring for one of 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) 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 November 27, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A stated the licensee completed initial, 14-day, 90-day, and change in condition assessments. R1 was admitted and began receiving services on September 25, 2023.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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 12 R1's record included an initial comprehensive assessment dated September 25, 2023, and a 14-day assessment dated October 6, 2023.R1's 14-day assessment did not include all the required elements on the uniform assessment tool. On November 29, 2023, at 12:40 p.m., clinical nurse supervisor (CNS)-B stated she did the comprehensive assessment initially then used a different paper for the 14-day assessment which did not cover the requirements for the uniform assessment tool. CNS-B stated she was not aware the comprehensive assessment needed to be used for all assessments. The Minnesota Administrative Rule 4659.0150 dated August 11, 1021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's undated Comprehensive Resident Assessment policy indicated the initial comprehensive assessment must be conducted in person by a registered nurse and include the following elements: personal lifestyle preferences including sleep schedule, dietary needs, leisure activities, spiritual and cultural preferences, and advance health directives. Activities of daily living including toileting, dressing, grooming, bathing, mobility, dental status, oral care and eating. Independent activities of daily living including ability to self-manage medications, laundry and transportation needs. Physical health status including a relevant health history and current health conditions, allergies and sensitivities to medications, environment, and food and if any of these are life threatening. In addition to general health status/system assessment, the agency comprehensive assessment tool will include:	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112			
(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 13 demographics and client history, living arrangement and support systems, integumentary status, neuro/emotional/behavioral status, functional limitations in completing activities of daily living, assessment of all medication the client is taking, vulnerability and safety assessment to determine risk of being abused and risk of abusing others, nutritional assessment to identify those at risk due to inadequate fluid and food availability or willingness of client to follow plan, equipment needs and ability to manage equipment, identification of advance directives, POLST, or specific emergency response instructions the client has and coordinating inclusion of those wishes into a resident's plan of care, emergent care data, items collected at resident's facility admission and discharge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain current medication orders for one of one resident (R1).	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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
01820	Continued From page 14 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's service plan dated September 25, 2023, indicated R1 received assistance with medications. On November 28, 2023, at 12:05 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's current medication administration record dated November 2023, included the following scheduled medications: -acetaminophen 500 mg -amitriptyline 10 mg -anastrozole 1 mg -aspirin 81 mg -atorvastatin 20 mg -Bydureon BC inj 2 mg/0.85 mL -carvedilol 6.25 mg -duloxetine 60 mg -Eucerin cream -ferrous sulfate 325 mg -fluticasone propionate inhaler 100 mcg -fluticasone propionate 50 mcg/act suspension -furosemide 20 mg -gabapentin 600 mg -latanoprost 0.05% -losartan 25 mg	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112			
(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
01820	Continued From page 15 -Metformin 1000 mg -NovoLog flex pen 100u/mL -senna-S 8.6-50 mg -spironolactone 50 mg -tab a vite -vitamin D3 1000u R1's record included an after-visit summary dated October 25, 2023. The after-visit summary was not signed by a provider although a few of the medications had electronic signatures from various providers. The after-visit summary lacked provider signatures for the following medications: -amitriptyline -carvedilol -duloxetine -ferrous sulfate -fluticasone propionate inhaler -fluticasone propionate suspension -furosemide -gabapentin -latanoprost -Senna-S -spironolactone -tab a vite On November 29, 2023, at 12:40 p.m., clinical nurse supervisor (CNS)-B stated when R1 first moved in they used the medication list from R1's previous facility. R1 had not been seen by a doctor for over a year and did not have a primary physician. The facility brought her into the doctor for a medication review but did not get the after-visit summary signed. CNS-B further stated she was not aware an after-visit summary did not count as signed doctors' orders. The licensee's undated Medication Prescriptions and Refills policy indicated a current, written	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2023
NAME OF PROVIDER OR SUPPLIER INSPIRE CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SILVER LAKE ROAD NW NEW BRIGHTON, MN 55112		
(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
01820	Continued From page 16 prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01820			



Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: 11/28/23
Time: 10:45:00
Report: 1047231082

Food and Beverage Establishment Inspection Report

Page 1

Location:

Inspire Care Inc
610 Silver Lake Road Nw
New Brighton, MN55112
Ramsey County, 62

Establishment Info:

ID #: 0039224
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516210722
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.

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

SHELF IN REFRIGERATOR IS BROKEN & REPAIRED WITH TAPE. FACILITY STATED THEY ORDERED A NEW PART THAT IS ON BACK ORDER CURRENTLY. REPAIR BROKEN PARTS OF FRIDGE.

Comply By: 11/28/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

DEBRIS BUILD UP ON EDGES OF KITCHEN FLOOR (EX. WHERE FLOOR MEETS WALL BY ENTRANCE, WHERE FLOOR MEETS REFRIGERATOR). CLEAN UP BUILT UP DUST/DEBRIS.

Comply By: 12/05/23

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit

Location: Sanitizer bucket

Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit

Location: Dishmachine

Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: 11/28/23
Time: 10:45:00
Report: 1047231082
Inspire Care Inc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator- cheese slices
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: REfrigerator- yogurt
Violation Issued: No

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

Inspection was conducted with operator M. Adam & MDH Nurse Evaluator W. Robarge.

The establishment has a residential kitchen and serves food that is prepared that day. Currently the facility has 2 residents. The kitchen has wood cabinets, tile floor, painted walls, solid counter top & a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, final cooking temperatures, temperature control, cleaning, high susceptible population guidance, and food handling procedures.

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

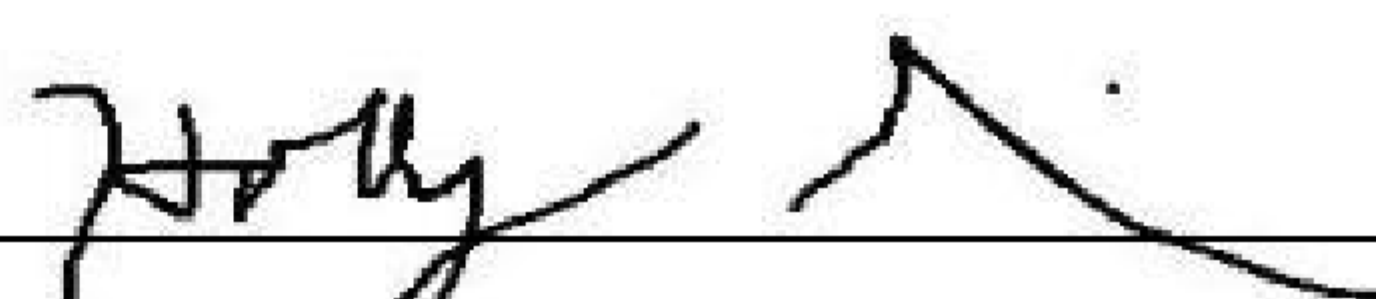
I acknowledge receipt of the Minnesota Department of Health inspection report number 1047231082 of 11/28/23.

Certified Food Protection Manager Munira Adam

Certification Number: FM108767 Expires: 09/15/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Munira Adam
PIC

Signed:  _____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us