Electronically Delivered

December 19, 2024

Licensee
Franklin Martins LLC
6224 Quail Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL40617015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on November 13, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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 Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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

Per 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 residents/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 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 Department of Health within 15 calendar days of the correction order receipt date.

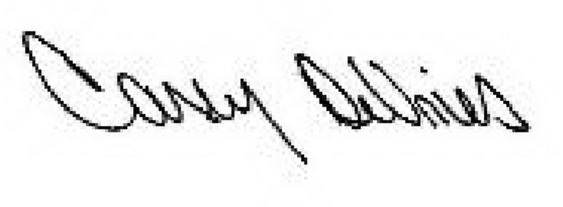
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40617	A. BUILDING: _____ B. WING _____	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MARTINS LLC	6224 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429

(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: SL40617015-0 On November 12, 2024, through November 13, 2024, 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 was one resident who resided at the facility. They received services under the provider's 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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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0 480	Continued From page 1 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean	0 480		

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0 480	Continued From page 2 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 had the potential to affect all residents of 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) 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 included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 12, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on November 13, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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

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0 550	Continued From page 4 On November 12, 2024, at 10:14 a.m., during the facility tour with assisted living director (ALD)-D, the surveyor observed the licensee lacked a grievance posting with the required name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. ALD-D stated they thought it was in their postings and were aware of the requirement. The licensee's Complaint Policy and Procedure dated January 1, 2024, indicated: 2. The written notice includes: a. The resident's right to complain to our facility about the services received from our staff; b. The method of submitting a complaint to our facility; and c. A description of the facility's complaint resolution process available to residents d. The name and contact information of the person representing the facility designated to handle and resolve complaints. e. The contact information for the Office of Ombudsman for Long-term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. f. A statement that our facility will not take any action that negatively affects a resident in retaliation for a complaint made or a concern expressed by the resident or the resident's representative." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 660	Continued From page 5	0 660		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure tuberculosis (TB) testing was completed within 90 days prior to the date of hire and failed to ensure a completed TB symptom screening was on record for one of two employees (unlicensed personnel (ULP-B)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 660		

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0 660	Continued From page 6 The licensee's facility TB risk assessment dated November 13, 2024, indicated the facility was at a low risk level. ULP-B was hired on October 4, 2024, to provide direct cares to residents. ULP-B's employee record included a TB Gold (TB blood test) collected on March 13, 2024, 245 days prior to ULP-B's date of hire. ULP-B's employee record lacked a completed TB symptom screening. On November 12, 2024, at 11:24 a.m., assisted living director (ALD)-D stated they did not have symptom screening for ULP-B and did not know it was required to have documented. On November 12, 2024, at 11:27 a.m., ALD-D stated they thought TB test results were able to be used for up to 12 months and was unaware it was 90 days. On November 13, 2024, at 8:37 a.m., the surveyor observed ULP-B administer medication to R1. The CDC Tuberculosis Guidance website, last updated December 15, 2023, indicated all health personnel should receive baseline TB screening and testing upon hire. The Minnesota Department of Health TB FAQ, last updated on October 15, 2024, indicated: - TB testing should be dated within 90 days before hiring; and - baseline TB screening is required at the time of hire for all health care personnel in Minnesota.	0 660		

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0 660	Continued From page 7 The licensee's TB Prevention and Control policy dated January 1, 2024, indicated: "At time of hire and prior to any contact with residents, all assisted living employees and all volunteers will be screened for Tuberculosis. a. Prior to contact with residents, the RN will review TB symptoms with each new assisted living employee and with any volunteers having direct resident contact. b. Prior to contact with residents, each staff person will be screened for TB. A two-step skin test or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold-InTube, TSPOT ®.TB) will be administered unless the person's past medical history indicates that a TB skin test is contraindicated. Individuals who have been vaccinated with Bacillus Calmette Guerin (BCG) vaccine are not exempt from tuberculin skin testing. Pregnant women are not exempt from tuberculin skin testing unless they have filed the exemption form for TB skin testing of a pregnant health care worker. The RN will follow the MDH guidance in 06-009 regarding how to screen employees with a previous or current positive TST or TB blood test or with a documented history of previous treatment for latent TB infection (LTBI) or active TB disease. For any questions the RN will contact the MDH TB staff at 651-201-5414 or 1-877-676-5414 and/or visit http://www.health.state.mn.us/divs/idepc/diseases/tb/tst.html#two." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 8	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and display prominently a written emergency preparedness plan (EPP) with all the required content for staff, residents, and visitors to view. 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	0 680		

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0 680	Continued From page 9 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 12, 2024, at 10:14 a.m., during the facility tour with assisted living director (ALD)-D, the surveyor observed the licensee lacked an EPP posted prominently. On November 12, 2024, at 12:01 p.m., the surveyor requested the licensee's EPP and its location. ALD-D stated they would need to look through their records and began looking through their computer. On November 12, 2024, at 12:20 p.m., the surveyor reviewed the licensee's Emergency Operations Program and Plan Manual reviewed/revised on March 2, 2024. It was an EPP template which was not fully tailored to the licensee and lacked the following required information: - take an all-hazards approach, including EIDs, as applicable; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); - quarterly review of the missing resident plan; - must include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - identification of which staff would assume specific roles in another's absence through	0 680		

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0 680	Continued From page 10 succession planning and delegation of authority; - arrangements and agreements with facilities receiving their residents in the event of evacuation; - shelter in place needs; - resident evacuation priority level of assistance; - development of P/P (policy/procedure) for at minimum food, water and pharmaceutical supplies; - development of P/P for sewage and waste disposal; - development of P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - development of P/P to address: use of volunteers, including the process/role for integration; - development of a communication plan to include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan must include: primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; - development of a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and - development of a communication plan which included: - method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care; -means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii);	0 680		

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0 680	Continued From page 11 -means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). On November 12, 2024, at 12:51 p.m., ALD-D stated the EPP was not posted prominently. ALD-D stated they sent everything they had for their EPP to the surveyor via email. ALD-D stated the EPP was incomplete and they were still actively working on it and was aware of the requirements. The licensee's Emergency Operations Program and Plan Manual dated March 2, 2024, indicated: "This document describes the Emergency Operations Program and Plan (EOP) for [licensee]. Our facility's EOP uses an "all-hazards" approach for emergency planning and response. This includes several elements: -An integrated approach to emergency preparedness planning with a focus on essential capabilities/capacities for effective response to a wide range of emergencies and disasters -An Emergency Operations Plan based on a risk assessment that addresses the array of hazards that this facility may face -Policies and procedures with strategies that reflect our population's unique needs and vulnerabilities -Collaboration with local, state and federal response partners -Coordination with other health facilities -A detailed communication plan -Continuity of operations strategies for response and recovery -Training that applies to all members of program administration and staff in all departments and non-staff members who perform work at the site including clinical providers, technicians,	0 680		

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	40617	A. BUILDING: _____ B. WING _____	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MARTINS LLC	6224 QUAIL AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 680	Continued From page 12 contractors, students, volunteers, and ancillary staff -Annual testing of the plan with the goal of identifying areas for further planning." 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 maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a	0 790		

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0 790	Continued From page 13 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 a facility tour on November 13, 2024, from 10:30 a.m. to 11:00 a.m., with assisted living director (ALD)-D, it was observed that the required fire extinguisher did not include documentation of annual required service and monthly inspection. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During the facility tour ALD-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790		
0 800 SS=E	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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0 800	Continued From page 14 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect more than a limited number of 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On a facility tour on November 13, 2024, from 10:30 a.m. to 11:00 a.m., with assisted living director (ALD)-D, the surveyor made the following observations of facility disrepair: WINDOW WELL MAINTENANCE The floor surface of the window well was covered with leaves and debris to a height that effected the operation of the emergency escape and rescue window in unoccupied resident sleeping	0 800		

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0 800	Continued From page 15 room five. Emergency escape and rescue window wells are required to be maintained free of obstructions that prevent full and immediate use and operation of the window. GENERAL MAINTENANCE The door would not close and latch leading into the mechanical/ laundry room. The door was out of adjustment and would not close fully into the door jamb. The exterior storm door would not close and latch and was missing the closer arm on the side door leading out of the kitchen. During a facility tour on ALD-D, verified the above listed observations while accompanying on the tour. 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 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	0 810		

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0 810	Continued From page 16 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 observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 17 On November 13, 2024, at 10:00 a.m., assisted living director (ALD)-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The location and number of resident sleeping rooms were not identified on the posted FSEP evacuation floor plan. Resident sleeping room numbers are required to be included on the evacuation floor plan in order to direct building occupants to an exit in the event of a fire or similar emergency. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP, failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on November 13, 2024, at 10:15 a.m., ALD-D, stated the above listed documentation in the FSEP was not available.	0 810		

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0 810	Continued From page 18 TRAINING Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation FSEP training was provided to the current resident upon admission in September of 2024. During an interview on November 13, 2024, at 10:20 a.m., ALD-D, stated documentation was not available required training was provided to residents. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation required drills were completed by employees as required. The surveyor explained evacuation drills are required to be completed and documented even when no residents are admitted in order to be prepared for newly admitted residents. During an interview on November 13, 2024, at 10:25 a.m., ALD-D, stated no residents were admitted to the facility until September 2024, and they had not completed or documented required evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative	0 950		

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0 950	Continued From page 19 (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include verbatim language, separate from the resident contract, giving residents the right to identify a designated representative for one of one resident (R1). This practice resulted in a level one violation (a	0 950		

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0 950	Continued From page 20 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 the potential to affect a large portion or all the residents). The findings include: The licensee's blank Resident Agreement updated in 2022, included the verbatim designated representative requirement on page 17, however it was not on its own page separate from the contract and included information about consent, indemnification, and liability. Additionally, the space for designating or declining a representative was not on the same page as the verbatim language; it was on page one of the contract along with rent and fee information. R1 was admitted to the licensee on September 29, 2024. R1's Resident Agreement signed on September 29, 2024, was the same contract as the above-mentioned blank Resident Agreement. On November 12, 2024, at 1:25 p.m., assisted living director (ALD)-D stated the blank contract was currently in use and was used for R1. ALD-D stated they were not aware the designated representative information was required to be on its own page separate from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		

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03090	Continued From page 21	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required verbatim notice was posted at the facility main entrance to disclose electronic monitoring activity. 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 the potential to affect a large portion or all the residents). The findings include: On November 12, 2024, at 9:28 a.m., the surveyor observed the facility front door and entrance way which had video monitoring signs, however lacked the video monitoring required verbatim language. On November 12, 2024, at 10:14, during the facility tour with assisted living director (ALD)-D the surveyor again observed the front door and entry way video monitoring signs which lacked	03090		

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03090	Continued From page 22 the required verbatim language. ALD-D stated they were unaware their signage did not include the required verbatim language. The licensee's Electronic Monitoring Policy and Procedure, undated, indicated "[licensee] shall post a sign at each [licensee] entrance accessible to visitors that states, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *11/12/24*
Time: 10:37:57
Report: 1021241348

Food and Beverage Establishment Inspection Report

Location:
FRANKLIN MARTINS LLC
6224 QUAIL AVENUE NORTH
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0043805
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

AN OPEN HALF GALLON OF MILK AND A BAG OF SHREDDED MOZZARELLA CHEESE FOUND IN THE KITCHEN REFRIGERATOR WITH NO DATE MARK. PER CONVERSATION WITH STAFF, THEY WERE OPENED YESTERDAY. STAFF WILL DATE MARK TCS FOOD ITEMS.

Comply By: 11/12/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN RESIDENTIAL DISH MACHINE. ONE THERMOLABEL LEFT ON-SITE TODAY. SEE COMMENTS.

Comply By: 11/20/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

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

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE.

Comply By: 11/20/24

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) EMPLOYED AT THIS ESTABLISHMENT. PER CONVERSATION WITH STAFF, THEY ARE IN THE PROCESS OF GETTING A CFPM CERTIFICATE. INFORMATION SENT WITH REPORT.

Comply By: 12/13/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: MILK - KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: YOGURT - KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 34 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH ALD-D, MARTINS SADO AND HEALTH REGULATION DIVISION NURSE EVALUATOR, JOEY KEEN.

CONTINUATION OF MN Rule 4626.0710B
STAFF ARE GOING TO RUN THE DISH MACHINE AND THEY ARE GOING SEND A PICTURE OF THE THERMOLABEL TO INSPECTOR TO MAKE SURE THE DISH MACHINE IS REACHING A FINAL UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 1 CLIENT AND THE FACILITY CAN HAVE UP TO 5 CLIENTS.

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

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, PAINTED DRYWALL AND NON-INTEGRAL BASE COVE. PHYSICAL FACILITY ITEMS WILL BE MONITORED
DURING FUTURE INSPECTIONS.

Type: Full
Date: *11/12/24*
Time: 10:37:57
Report: 1021241348
FRANKLIN MARTINS 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 1021241348 of 11/12/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
MARTINS SADO
ALD-D

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