Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 7, 2022

Administrator
Everbloom Home Healthcare, LLC
6401 132nd Street West
Apple Valley, MN 55124

RE: Project Number(s) SL37653015

Dear Administrator:

On September 9, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on July 7, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the July 7, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on July 7, 2022, found not corrected at the time of the September 9, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) = $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on September 9, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:
Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

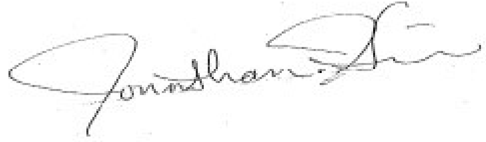
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37653	A. BUILDING: ______ B. WING ______	R 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERBLOOM HOME HEALTHCARE LLC	**6401 132ND STREET WEST APPLE VALLEY, MN 55124**

(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 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 a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. SL37653015 On September 6, 2022, through September 9, 2022, a surveyor with the Minnesota Department of Health conducted a follow-up survey to verify correction of order(s) issued at the time of the July 7, 2022, licensing survey. As a result of the follow-up survey, the following orders have been reissued.	{0 000}		
{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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and	{0 480}		

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{0 480}	Continued From page 1 fresh vegetables. The following apply: (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: No further action required.	{0 480}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in	{0 780}		

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{0 780}	Continued From page 2 existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the interconnection of required smoke alarms for the home. This has the potential to directly affect 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 of the residents). The findings include: On September 8, 2022, approximately from 12:45 p.m. to 2:00 p.m., survey staff toured the home with the owner (O)-A. Survey staff observed the following findings during the tour: 1) The smoke alarm located in the hallway outside on the main level bedroom next to resident bedroom #C was not interconnected with the home's smoke alarm system when the O-A tested the alarm. The finding was evident as the alarm sounded local and only activated a newly installed smoke alarm in the downstairs hallway next to the living room and failed to activate all other smoke alarms in the home. The O-A explained that her contractor changed this smoke alarm and worked on the interconnection and reassured her the smoke alarms were interconnected to sound throughout the home. The O-A verified the finding and stated she now	{0 780}		

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{0 780}	Continued From page 3 understood the requirement of interconnection after further discussion with survey staff. 2) The smoke alarm located in the lower-level resident bedroom # 5 and the hallway outside of the resident bedroom #5 were tested by the O-A and were not interconnected with the home's smoke alarm system to activate and sound all other smoke alarms in the home as required. The O-A confirmed the finding. On September 8, 2022, at approximately 2:45 p.m., the O-A acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		

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{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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 are: On September 8, 2022, approximately from 12:45 p.m. to 2:00 p.m., survey staff toured the home with the owner (O)-A. Survey staff observed the following findings during the tour: 1) The shower tile wall in the upstairs bathroom had loose plastic covering the shower tile wall in its entirety. Survey staff about the plastic cover in the shower and the O-A explained that the previous ponding and water leakage in the	{0 800}		

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{0 800}	Continued From page 5 lower-level mechanical room were from the water penetration in the tile wall when the shower in the upstairs bathroom was used. The O-A stated that the contractor will be here in a week to repair the tile in the shower. 2)The egress windows in resident bedrooms #C and #D had a temporary repair to enable the windows to open immediately in case of emergency. Both windows have not been permanently repaired and/or replaced with proper and standard window hardware to provide security of the home from unauthorized entry. This poses a safety risk to residents and staff. The O-A showed a quote she received from the hardware store and stated that a contract had not been signed but she will decide to order window replacements soon. On September 8, 2022, at approximately 2:45 p.m., the O-A acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and 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	{0 810}		

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{0 810}	Continued From page 6 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: No further action required.	{0 810}		
{0 820} SS=I	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	{0 820}		

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{0 820}	Continued From page 7	{0 820}		

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:
No further action required.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 3, 2022

Administrator
Everbloom Home Healthcare, LLC
6401 132nd Street West
Apple Valley, MN 55124

RE: Project Number(s) SL37653015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 7, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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 enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000.00

The total amount you are assessed is $6,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. <u>Please note that you may request a reconsideration **or** a hearing, but not both</u>.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

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0 000	Initial Comments 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: SL37653015 On July 6, 2022, through July 7, 2022, 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 three residents, all of whom received services under the provider's Assisted Living license. On July 7, 2022, an immediate correction order was issued at approximately 3:30 p.m., for 0820 and 2310. On July 8, 2022, the immediacy of 2310 was removed and the 0820 order remained in place, the scope and level of noncompliance remain the same.	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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of assisted living services (UDALSA) with the required content for one of one residents (R1) with records reviewed. This had the potential to affect all three residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 430		

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	37653	A. BUILDING: ____ B. WING ____	07/07/2022

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0 430	Continued From page 2 The findings include: R1's record lacked documentation of receipt of a UDALSA. R1's 90 day assessment, dated May 25, 2022, indicated services that include personal cares, and medication management. On July 6, 2022, at approximately 9:35 a.m., unlicensed personnel (ULP)-C was observed to administer R1's morning medications. On July 7, 2022, at approximately 3:00 p.m., owner-A said she did have a current UDALSA for licensee clients, but verified it had not been completed or signed by each client. The licensee lacked a policy regarding the uniform checklist disclosure of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 3 (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 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 included document titled, Food and Beverage Establishment Inspection Report dated July 6, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for	0 490		

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0 490	Continued From page 4 transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities that are based upon individual and group interests or physical, mental, and psychosocial needs. 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 included:	0 490		

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0 490	Continued From page 5 On July 6, 2022, at 11:00 a.m., during a tour of the facility, the surveyor observed the main entrance area and noted the lack of a daily activity schedule posted. On July 6, 2022, at 12:00 p.m., owner (O)-A stated, the residents do their own activities, such as watching television or playing video games in their private rooms. O-A stated the licensee employees take the residents on outings, but stated the outings occurred less often during the pandemic. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: July 6, 2022, at 10:00 a.m. Based on observation, interview and record review, the licensee failed to establish and	0 510		

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0 510	Continued From page 6 maintain infection control program that complied with accepted health care, medical, and nursing standards for infection control related to the COVID-19 pandemic when the licensee failed to ensure visitors, employees, and residents were screened for COVID-19 with temperature checks and screening questions. 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 all four residents). The findings include: On July 6, 2022, at 10:00 a.m., unlicensed personnel (ULP)-C answered the door of the licensee's housing with services/HWS. ULP-C was not wearing personal protective equipment (PPE), including a face mask. ULP-C escorted the surveyor to the living room area. The employee did not screen the surveyor for signs and symptoms of COVID-19 or perform a temperature check. The Minnesota Department of Health's COVID-19 PPE and Source Control Grids dated April 7, 2022, indicated all employees who work in a congregated health care setting, including assisted living facilities, are recommended to wear a face mask when in areas they could encounter residents. On July 7, 2022, at 3:00 p.m., owner (O)-A stated ULP-C was trained to screen and check the temperatures of all visitors to the HWS, and should have screened the surveyors upon arrival	0 510		

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0 510	Continued From page 7 to the HWS. The licensee lacked a policy on the current Covid-19 guidelines. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
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; 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 development of an individual abuse prevention plan with the required content for one of one resident (R1), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 630		

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0 630	Continued From page 8 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 diagnoses included hypertension. R1's Master Care Plan, dated January 27, 2022, , indicated R1 received services which included medication administration. . R1 lacked development of an Abuse Prevention Plan to include 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; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On July 7, 2022, at 3:00 p.m., owner (O)-A verified R1's record lacked an individualized Abuse Prevention Plan to include the above requirements. The licensee's undated Abuse Prevention Plan policy verified the plan will "identify areas of vulnerability and safety concerns. Interventions to identify areas of concern will be documented on the plan and included on the resident care plan." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 680	Continued From page 9	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 tenant 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 ensure a written emergency disaster plan with all required content outlined in Appendix Z was completed by the licensee. This had the potential to affect all three current residents, staff, and visitors.	0 680		

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0 680	Continued From page 10 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 July 7, 2022, at 3:00 p.m., owner (O)-A verified the emergency preparedness plan had not been developed to include the required information. O-A stated the licensee had policies for emergency preparedness, but verified the policies were not individualized to the licensee's housing with services (HWS). O-A stated she was not aware of all of the requirements of Appendix Z. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity	0 780		

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0 780	Continued From page 11	0 780		

of bedrooms;
(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;
(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and
(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to provide the interconnection and the minimum number of smoke alarms. This has the potential to directly affect 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 of the residents).

The findings include:

On July 7, 2022, approximately from 10:40 a.m. to 12:30 p.m., survey staff toured the home with owner(O)-A. Survey staff observed the following findings during the tour:

1) The smoke alarm located in the hallway

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0 780	Continued From page 12 outside on the main level bedroom next to resident room #C was not interconnected with the home's smoke alarm system. Survey staff observed that the smoke alarm was the only unit that was different from the other smoke alarms on the main floor. The unlicensed personnel (ULP)-C removed and opened the smoke alarm and it was a battery type. O-A clarified that all other smoke alarms in the home were hardwired. The ULP-C and the O-A verified the finding. 2) The smoke alarms located in the lower-level resident room # 5 and the lower-level hallway both sound when tested but were not interconnected with the home's smoke alarm system to sound the alarms on the main floor. The LALD-A confirmed that these two smoke alarms were not interconnected with the alarms on the main floor. On July 7, 2022, at approximately 2:30 p.m., at the exit interview the O-A acknowledged the findings. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790		

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0 790	Continued From page 13 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, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). 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, 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 the potential to affect a large portion or all of the residents). The findings include: On July 7, 2022, approximately from 10:40 a.m. to 12:30 p.m., survey staff toured the home with owner (O)-A. Survey staff observed the following findings during the tour: MINIMUM SIZE REQUIRED The portable fire extinguishers did not meet the required minimum rated type, 2-A:10-B:C. Survey staff observed that the label on the units with rated type 1-A:10-B:C. MAINTENANCE/INSPECTIONS The extinguishers were observed with no tags	0 790		

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0 790	Continued From page 14 attached to indicate the required annual service and monthly inspections from this year, or any previous years. On July 7, 2022, at approximately 2:30 p.m., at the exit interview the O-A acknowledged the findings and asked if she can use the larger portable fire extinguishers from a different home that had been sitting on the kitchen counter. Survey staff explained to O-A that those two units on the counter were not acceptable as one unit had the needle reading "empty" and the other unit was missing the pin. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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, 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 physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff.	0 800		

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This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings are:

On July 7, 2022, approximately from 10:40 a.m. to 12:30 p.m., survey staff toured the home with owner (O)-A. Survey staff observed the following findings during the tour:

1) The clothes washer had standing water inside the unit. The O-A explained that maintenance has been called for repair and/replacement and they were temporary washing clothes at a different location.

2) The lower window well for unoccupied resident room #E (lower level floor) had a weather protective cover that obstructed the opening of the egress window when the O-A cranked the handle with a clear openning of about three inches. Survey staff explained although the room currently was not occupied, the egress window opening not be obstructed and the window well must be kept cleared of all obstructions for immediate use for safe egress from the home during a fire or emergency. The O-A verified the finding and stated that she will make sure the protective cover will be fixed by raising it up so not to obstruct the window from being opened.

3) The encasement cranked type windows on the main floor unoccupied resident room # B did not

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	37653	A. BUILDING: ______ B. WING ______	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERBLOOM HOME HEALTHCARE LLC	**6401 132ND STREET WEST APPLE VALLEY, MN 55124**

(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 16 meet the minimum clear width opening dimension of 20 inches when measured. Survey staff measured the clear window opening dimensions with width at 16 inches and height at 49 inches for both windows. Survey staff explained to the O-A that the window opening height was acceptable but the widow width opening dimension of 16 inches did not meet the state standard minimum clear width requirement of 20 inches. Survey staff advised the O-A to review the location of the hinge and elbow with a professional to see if that may relocated the hinge to provide for a minimum width opening of 20 inches. If not, the O-A must replace the window. 4) The mechanical room floor was observed with some ponding of water in various locations. Survey staff asked the O-A about the ponding (standing) water on the floor and she was unclear of the cause. Upon further investigation, survey staff observed: -water droplets and sweating on the plumbing pipe from the above, -water droplets and dark discoloration in the wood in ceiling, - 4-inch wide pieces of plastic material used as dams to contain or stop flow of water in the mechanical room near the furnace/water heater and also, multiple pieces were used outside wall in the open community room adjacent to the mechanical room wall near the desk/office area, - The wood stud in the mechanical room near the furnace showed signs of dark discoloration from water leakage/sweating in the room that included growth of mold. The O-A verified the findings and asked for more information on mold. Survey staff explained that to the O-A that she will need to consult with a licensed professional to repair the leak and/or unclogged any indirect piping from the equipment	0 800		

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0 800	Continued From page 17 in the room to eliminate the standing water and the mold. 5)Survey staff observed extension cord was used near the fireplace outlet. Survey staff explained that the use of extension cords pose potential electrical fire hazard from overloading the electrical circuits. On July 7, 2022, at approximately 2:30 p.m., at the exit interview the O-A acknowledged the findings. No Further information was provided. 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 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.	0 810		

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0 810	Continued From page 18	0 810		

Continued From page 18

(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, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the required training on fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, 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 of the residents).

The findings include:

On July 7, 2022, at approximately 1:00 p.m., survey staff received and reviewed the home's fire safety and evacuation documentation, the

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evacuation drill, and the training documentation.

FIRE SAFETY AND EVACUATION PLAN
1)The plan documentation lacked fire protection procedures for residents.
2)The plan documentation lacked floor plans to show location and numbers of resident rooms. Owner (O)-A stated that she was currently working on the floor plans when staff has asked about them.

TRAINING
Documentation review showed the licensee lacked record of employee training on the fire safety and evacuation plan for the home. The minimum required employee training is upon hire and twice a year. Survey staff explained that the fire safety and evacuation training requiirements were in addition to the annual required emergency preparedness plan training.

EVACUATION DRILLS
No fire safety and evacuation drill records were provided for review. Furthermore, documentation review showed the licensee's policy incorrectly adopted policy that required employee drills to be performed every 6 months. O-A explained that they have performed two drills, July 2021 and December 2021, but did not provide written records of the drills.

On July 7, 2022, at approximately 2:30 p.m., at the exit interview O-A acknowledged the findings.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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0 820 SS=I	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 failed to ensure all physical facility elements including proper egress window hardware to open egress windows for immediate use and to maintain the minimum size egress window openings for resident bedrooms, do not create a distinct hazard to residents and staff. This affected occupied resident rooms #C and #D. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	0 820		

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0 820	Continued From page 21	0 820		

On July 7, 2022, approximately from 10:40 a.m. to 12:30 p.m., survey staff toured the home with owner (O)-A. Survey staff observed the following findings during the tour:

At approximately 11:00 a.m., O-A attempted to open the window in main-level resident room #D. The O-A failed to open the window with multiple attempts using the bar type hardware on the window. Survey staff observed the window hardware was a nonstandard type with no handle but a push-type bar in the middle of the window. At 11:30 a.m., the O-A again attempted to open the window by pushing on the bar. The window opened partially, as far as the elbow length of the bar hardware allowed. Survey staff measured the partially opened window with opening dimensions with width of 9.5 inches and height of 37 inches. In addition, the partially opened window was obstructed with the bar in the middle of the window reducing the window opening area by half. Survey staff explained to the O-A that the window opening failed to meet the minimum size egress window openings required for safe egress with measurements at width of 9.5 inches when opened and that the O-A failed to provide the proper window hardware that was operable for immediate use by staff and resident during a fire and similar emergency. O-A explained that the resident in room #D has signs of dementia and the unlicensed personnel-C-stated that the resident likes to leave. O-A verified the finding.

At approximately 11:25 a.m., survey staff and O-A entered the main-level resident room #C. Survey staff noticed the window was the same design as resident room #D with similar window hardware. Survey staff asked O-A to open the window and she was able to open the window but only partially. Survey staff measured the partially

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0 820	Continued From page 22 opened window with opening dimensions with width of 9.5 with height of 37 inches. Consistent with the window in room #D, the partially opened window had a bar in the middle of the window reducing the total egress window opening area by half. Survey staff explained to O-A that the window did not meet the minimum size egress window openings required for safe egress with the width of 9.5 inches when opened and O-A failed to maintain the window for readily operable for immediate use during a fire and similar emergency. O-A explained that the resident in room #C did not have any signs of dementia. O-A verified the finding. On July 7, 2022, at approximately 2:30 p.m., at the exit interview, survey staff explained to O-A that an immediate correction was issued for the above findings. Survey staff again explained to O-A that the egress windows must be easily operable without requiring special knowledge and the window openings must be free of any obstruction, and because of the door hardware installed, the window openings in resident rooms #C & D did not meet the minimum size openings for safe egress. O-A acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor	0 970		

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0 970	Continued From page 23 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all three residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's undated Resident Agreement, included a clause that indicated the resident would waive the facility's liability as follows: "We are not responsible for any damage or injury suffered by you, your property, your guests or their property that was not caused by us. We strongly recommend that Resident obtain renter's insurance at an appropriate level to insure against loss of Resident's personal property, as well as related incidental and consequential damages, or such other or additional insurance as Resident considers necessary to protect against injuries and property damage. Our insurance may not cover the loss of your personal property and the incidental and consequential damages arising from the loss of such property.	0 970		

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0 970	Continued From page 24 Your personal property included but is not limited to dentures, glasses and hearing aids (sic)." On July 7, 2022, at 3:00 p.m., owner (O)-A verified the Resident Agreement was the same assisted living service agreement was used for all residents of the facility. O-A stated she was not aware of the liability waiver requirement. The licensee lacked a policy for Assisted Living Licensure contract requirements. No further information available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by:	01420		

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Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel ((ULP)-F) who performed delegated tasks.

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:

ULP-F was hired by the licensee on June 1, 2020. ULP-F's employee record lacked evidence of completed training and competency evaluation for blood pressure monitoring by the registered nurse (RN).

On July 7, 2022, at 3:00 p.m., owner (O)-A acknowledged ULP-F's record lacked documentation of training and competency evaluation for blood pressure monitoring by a RN. O-A stated she would notify the RN and ensure the training and competency was completed for ULP-F.

The licensee's undated Employee Records policy indicated licensee employee are trained and competency tested "to demonstrate compliance with the Assisted Living License and Standards of Care" and documentation of the training would be included in the employee record.

No further information was provided.

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TIME PERIOD FOR CORRECTION:
Twenty-One (21) days

02310 SS=I — 144G.91 Subd. 4 Appropriate care and services — 02310

(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R2) with hospital bed rails.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).

This resulted in an immediate correction order on July 7, 2022.

The findings include:

On July 6, 2022, at approximately 10:00 a.m. bed rails were observed on both sides of R2's hospital bed. The rail on the right side of the bed was in the up position; the rail on the left side of the bed was in the down position.

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R2's diagnosis included essential hypertension. R2's undated service plan indicated R2 received assistance with cares and medication administration.

R2's record lacked evidence: the RN had conducted an assessment of the hospital bed rail; evidence the resident/responsible party were provided with the risks associated with the use of bed rails to the resident. The record lacked evidence the RN documented measurements to ensure the bed rails were consistent with the Food and Drug Administration (FDA) guidelines.

On July 7, 2022, at 12:00 p.m. registered nurse (RN)-D stated she completed a bed rail assessment, but did not take measurements, and "just eyeballed" the bed openings. RN-D stated she discussed the risks and benefits of bed rail use with the resident and family verbally, but did not document the encounter. RN-D stated the resident verbalized understanding.

On July 7, 2022, at 1:38 p.m. owner (O)-A stated upon admission, the family brought the hospital bed to the facility, and stated the bed rails were already on the bed. O-A stated she talked to R2 and family about the bed rail use, and she trained staff, but was unsure if the bed was measured for potential zones of entrapment. O-A was unsure if the risks and benefits of bed rail use was completed with R2.

On July 7, 2022, at 3:15 p.m. O-A stated the RN would come on July 8, 2022, at 9:00 a.m. to complete the measurements of the bedrail and the risk and benefits assessment.

The March 10, 2006, FDA Side Rail Entrapment

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Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.

The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's [resident's] physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."

The licensee's Side Rail Use policy dated May 2, 2020, verified the "RN will conduct a side rail assessment" and "discuss with the client/family alternatives to the use of side rails." "If the need for side rails is indicated and the client/family agree to their use, the RN will provide education related to side rails."

No further information was provided.

TIME PERIOD FOR CORRECTION: IMMEDIATE

On July 7, 2022, an immediate correction order was issued at approximately 3:30 p.m.

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EVERBLOOM HOME HEALTHCARE LLC	**6401 132ND STREET WEST APPLE VALLEY, MN 55124**

(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

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *07/06/22*
Time: 08:48:43
Report: 7963221060

Food and Beverage Establishment Inspection Report

Location:
Everbloom Home Healthcare Llc
6401 132nd Street West
Apple Valley, MN55124
Dakota County, 19

Establishment Info:
ID #: 0039028
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512357828
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

KITCHEN REFRIGERATOR- CUT WATERMELON AT 43 DEG F,MILK AT 42 DEG F.
ADJUST/REPAIR COOLER SO IT KEEPS FOODS AT 41 DEG F OR COLDER.

Comply By: 07/06/22

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

MET WITH MERIAM ABRAHAM. DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-COOKING TEMPERATURES
-PROPER SANITIZING OF UTENSILS AND DISHWARE
-RESTRICTIONS CONCERNING SERVING A SUSCEPTIBLE POPULATION
INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE SURVEYOR JOLENE. BERTELSEN AND DEB JACOBSON. FINDINGS SHARED AT END OF INSPECTION.
WILL EMAIL ASSORTED FACT SHEETS AND TEST FOR DETERMINING RINSE TEMPERATURE IN DISH MACHINE TO ESTABLISHMENT.
KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE. FLOOR IS LINOLEUM, CABINETS ARE PAINTED WOOD WITH HOLLOW BASE, COUNTERTOP IS SOLID SURFACE AND CEILINGS ARE POPCORN TEXTURE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

Food and Beverage Establishment Inspection Report

KITCHEN HAS A TWO BASIN SINK WITH ONE SIDE BEING USED FOR HANDWASHING. DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING CYCLE OPTION.

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 7963221060 of 07/06/22.

Certified Food Protection Manager: Meriam Abraham

Certification Number: FM 110787 Expires: 01/14/25

Inspection report reviewed with person in charge and emailed.

Signed: ____________________

Meriam Abraham
PIC

Signed: ____________________

Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963221060

Food Establishment Inspection Report

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	1	Date	07/06/22
No. of Repeat RF/PHI Categories Out	0	Time In	08:48:43
Legal Authority MN Rules Chapter 4626		Time Out	

Everbloom Home Healthcare Llc	Address 6401 132nd Street West	City/State Apple Valley, MN	Zip Code 55124	Telephone 6512357828
License/Permit # 0039028	Permit Holder	Purpose of Inspection Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

(Circled status shown in bold.)

#	Compliance Status	Item	COS	R
		Supervision		
1	**IN** OUT	PIC knowledgeable; duties & oversight		
2	**IN** OUT N/A	Certified food protection manager, duties		
		Employee Health		
3	**IN** OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	**IN** OUT	Proper use of reporting, restriction & exclusion		
5	**IN** OUT	Procedures for responding to vomiting & diarrheal events		
		Good Hygenic Practices		
6	**IN** OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	**IN** OUT N/O	No discharge from eyes, nose, & mouth		
		Preventing Contamination by Hands		
8	**IN** OUT N/O	Hands clean & properly washed		
9	**IN** OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	**IN** OUT	Adequate handwashing sinks supplied/accessible		
		Approved Source		
11	**IN** OUT	Food obtained from approved source		
12	IN OUT N/A **N/O**	Food received at proper temperature		
13	**IN** OUT	Food in good condition, safe, & unadulterated		
14	IN OUT **N/A** N/O	Required records available; shellstock tags, parasite destruction		
		Protection from Contamination		
15	**IN** OUT N/A N/O	Food separated and protected		
16	**IN** OUT N/A	Food contact surfaces: cleaned & sanitized		
17	**IN** OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		
		Time/Temperature Control for Safety		
18	IN OUT N/A **N/O**	Proper cooking time & temperature		
19	IN OUT **N/A** N/O	Proper reheating procedures for hot holding		
20	IN OUT **N/A** N/O	Proper cooling time & temperature		
21	IN OUT **N/A** N/O	Proper hot holding temperatures		
22	IN **OUT** N/A	Proper cold holding temperatures		
23	**IN** OUT N/A N/O	Proper date marking & disposition		
24	IN OUT **N/A** N/O	Time as a public health control: procedures & records		
		Consumer Advisory		
25	IN OUT **N/A**	Consumer advisory provided for raw/undercooked food		
		Highly Susceptible Populations		
26	**IN** OUT N/A	Pasteurized foods used; prohibited foods not offered		
		Food and Color Additives and Toxic Substances		
27	IN OUT **N/A**	Food additives: approved & properly used		
28	**IN** OUT	Toxic substances properly identified, stored, & used		
		Conformance with Approved Procedures		
29	IN OUT **N/A**	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.
Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

#	Status	Item	COS	R
		Safe Food and Water		
30	**IN** OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT **N/A**	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A **N/O**	Plant food properly cooked for hot holding		
35	**IN** OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/07/22

Inspector (Signature)