Electronically Delivered

June 22, 2023

Licensee
Shelter Arm LLC
9444 Fallgold Parkway North
Brooklyn Center, MN 55443

RE: Project Number(s) SL38781015

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 May 30, 2023, 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.

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 and enforcement actions 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.

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

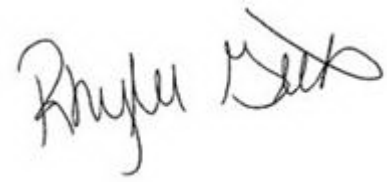
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
Email: rhylee.gilb@state.mn.us
Telephone: 218-232-8285 Fax: 651-215-6894

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38781	A. BUILDING: _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELTER ARM LLC	9444 FALLGOLD PARKWAY NORTH BROOKLYN CENTER, MN 55443

(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: SL#38781015 On May 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one (1) resident receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written staffing plan. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 470		

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0 470	Continued From page 2 or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on May 30, 2023, at 9:00 a.m., it was observed that the facility did not have a staffing plan posted. On May 30, 2023, at 10:30 p.m., the facility documents were reviewed. The facility documents did not include a facility staff plan. During an interview on May 30, 2023, at 10:35 p.m., registered nurse (RN)-A who is also the owner and the licensed assisted living director (LALD), stated staff members work in the facility twenty-four hours per day, and RN-A was the only nurse who was available twenty-four hours per day, every day of the week. RN-A stated the facility shifts are as follows: 7:00 a.m. to 7:00 p.m., 7:00 p.m. to 7:00 a.m. RN-A stated staff are awake when working during the night. No further information was posted or provided indicating a staffing plan. On May 30, 2023, at 2:00 p.m., the staff plan policy was requested but not received. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 3 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated May 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to	0 580		

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0 580	Continued From page 4 be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect the one resident receiving assisted living services. 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: During the entrance conference on May 30, 2023, at 9:00 a.m., the surveyor asked the registered nurse (RN)-A, who is also the owner and the licensed assisted living director (LALD), for the documentation of the licensee's quality management activities. RN-A indicated they didn't have a quality plan or a quality program. RN-A said she would start it right away. The licensees did not provide a quality management policy when requested.	0 580		

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0 580	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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 interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.	0 680		

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0 680	Continued From page 6 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: During the facility tour on May 30, 2023, at 9:15 a.m., the surveyors observed the entry area, common areas, and dining area within the facility with the registered nurse (RN)-A, who is also the owner and the licensed assisted living director (LALD), and did not observe signage posted or information regarding the licensee's EPP. There were no emergency exit diagrams to all residents on each floor. On May 30, 2023, at 10:00 a.m., RN-A stated the EPP had never been posted or developed at this facility. The regulations required the facility develop and maintain an EPP to contain 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	0 680		

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0 680	Continued From page 7 (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. and (c) The facility must meet any additional requirements adopted in rule. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated May 23, 2022, noted the EPP will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan would be based on our assisted living-based and community-based risk assessment, utilizing the all-hazards approach. Key elements of the plan include four primary components: 1. Emergency Plan that is based on a Hazard Vulnerability Assessment and incorporates an all-hazards approach; 2. Policies and Procedures; 3. Communication Plan; and 4. Training and Testing Program 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	0 780		

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0 780	Continued From page 8 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a smoke alarm in the upper-level resident bedroom #4 and the interconnection of required smoke alarms. This has the potential to directly affect the residents, visitors, 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).	0 780		

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0 780	Continued From page 9 The findings include: On May 30, 2023, approximately from 1:20 pm to 2:20 p.m., survey staff toured the home with the unlicensed personnel (ULP)-B. During the tour, survey staff observed the following: -The smoke alarms in the home were not interconnected so the actuation of one alarm causes all alarms to actuate, sounding throughout the home for proper notification. The findings were evident when the smoke alarms in the main-level hallway, the lower-level hallway, the upper-level hallway, and the main-level resident bedroom #1 sounded local when the ULP-B activated each smoke alarm during the home tour. -The upper-level bedroom #4 was missing a smoke alarm. The finding was evident as survey staff observed exposed wires in the ceiling where the smoke alarm had been removed. The listed findings were verified by the ULP-B accompanying the tour. On May 30, 2023, at approximately 3:00 p.m., at the exit interview, the registered nurse-A and the ULP-B acknowledged the above findings. 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	0 790		

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0 790	Continued From page 10 (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, record review, and interview, the licensee failed to correctly install the 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) 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 May 30, 2023, approximately from 1:20 pm to 2:20 p.m., survey staff toured the home with the unlicensed personnel (ULP)-B. During the tour, survey staff observed the portable fire extinguishers mounted at the incorrect height for the upper-level floor and the main-level kitchen at	0 790		

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0 790	Continued From page 11 approximately 7 feet above the finished floor. Portable fire extinguishers must be mounted at a maximum height of 5 feet above the floor to ensure all portable extinguishers are readily accessible for use. The listed findings were verified by the ULP-B accompanying the tour. On May 30, 2023, at approximately 3:00 p.m., at the exit interview, the registered nurse (RN)-A and the ULP-B acknowledged the above findings. The RN-A stated that they were supposed to be lowered from the previous site inspection. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 30, 2023, approximately from 1:20 pm to 2:20 p.m., survey staff toured the home with the unlicensed personnel (ULP)-B. During the tour, survey staff observed the following: -The main-level floor resident bedroom #1 door failed to latch when closed. -The lighting near the lower-level floor stairs was dark from a burned-out bulb. -The furnace housing had multiple cracks. The listed findings were verified by the ULP-B accompanying the tour. On May 30, 2023, at approximately 3:00 p.m., at the exit interview, the registered nurse (RN)-A and the ULP-B acknowledged the above findings. The RN-A stated the bulb near the lower-level stairs just literally burned out. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38781	A. BUILDING: _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELTER ARM LLC	9444 FALLGOLD PARKWAY NORTH BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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, document review, and interview, the licensee failed to provide all required contents on the fire safety and	0 810		

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0 810	Continued From page 14 evacuation plan, the minimum required training on the fire safety and evacuation plan, and the required evacuation drills. This has the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care. 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 May 30, 2023, approximately from 1:20 pm to 2:20 p.m., survey staff toured the home with the unlicensed personnel (ULP)-B. On May 30, 2023, at approximately 2:30 p.m., survey staff received the home ' s fire safety and evacuation plan and related documentation from the registered nurse (RN)-A. Document review and interview with the RN-A at approximately 2:45 p.m. indicated the following: -The posted home layout plans for the main-level floor and the upper-level floor lacked resident room locations. The RN-A verified the finding and agreed to revise the plans and include evacuation routes. -No floor plan layout for the lower-level floor. -The plan documentation lacked fire protection procedures for residents. - The plan documentation did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Survey staff explained that unique situations or logistics during	0 810		

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0 810	Continued From page 15 an evacuation may be residents who have mobility limitations, non-ambulatory, or any residents needing additional assistance during an evacuation that must be addressed in the fire safety and evacuation plan documentation. During the interview, the RN-A verified that the fire safety and evacuation plan for the facility lacked these provisions as she had asked for additional information on the evacuation plan. -The policy documentation lacked the records of employee training on the facility fire safety and evacuation plan upon hiring of employees (and at least twice per year thereafter). No records were available or provided for review for employees upon hiring in May of 2022. -The documentation lacked the required minimum number of employee evacuation drills to date. Record review indicated one evacuation fire drill was performed by employees to date, April 30, 2023, at 1:30 p.m. Survey staff explained to the RN-A that she had employees onboard since May 2022, and the minimum number of required evacuation drills that must be performed by employees is upon hire and twice per year per shift, thereafter, with at least one evacuation drill every other month, for a minimum total of six evacuation drills per year. On May 30, 2023, at approximately 3:00 p.m., at the exit interview, the RN-A and the ULP-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 16 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one staff, unlicensed personnel (ULP-B) 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	01440		

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01440	Continued From page 17 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 30, 2023, at 12:10 p.m., ULP-B and registered nurse (RN)-A, both confirmed ULP-B passes medication for the resident living at the facility. ULP-B was hired on May 23, 2022, to provide direct care services to the facility's residents. ULP-B's employee record lacked a 30-day supervision by the RN of ULP-B performing a delegated task within 30 days of beginning work with the licensee. On May 30, 2023, at 12:12 p.m., RN-A confirmed a 30-day supervision of ULP-B had not been completed for ULP-B or any other employees at the facility. The licensees did not provide a policy for Supervision of Licensed and Unlicensed Personnel when requested. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to	01790		

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01790	Continued From page 18	01790		

exceed seven calendar days;
(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that

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01790	Continued From page 19 medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure one of one unlicensed personnel (ULP)-B, and all other ULPs were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01790		

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01790	Continued From page 20 UNPLANNED TIME AWAY POLICY AND PROCEDURE FOR ULP The licensee's Medication Management - Planned and Unplanned Time Away policy dated May 23, 2022, indicated for unplanned client time away when a pharmacist or licensed nurse was not available, the RN may delegate this task to ULP if the RN has trained the ULP and determined the ULP to be competent to follow the procedures for giving medications to clients. The RN needs to develop written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The licensee's policy lacked the written procedure to include: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the RN shall be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative. - a review by the RN of the completion of this task to verify that this task was completed accurately	01790		

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01790	Continued From page 21 by the ULP; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication On May 30, 2023, at 10:06 a.m., registered nurse (RN)-A, who is also the owner and licensed assisted living director (LALD), stated the unplanned time away procedure had not been developed and confimed staff had not been trained on the process. TRAINING AND COMPETENCY EVALUATIONS R1's medication administration records (MAR) dated may 2023, showed ULP-B had passed medications to residents. ULP-B was hired on May 23, 2022, and began providing assisted living services including medication administration. ULP B's employee record lacked documentation of the planned and unplanned time away proceedure being trained and a competency being completed. The licensee's Medication Administration-Planned and Unplanned Time Away policy dated May 23, 2022, indicated the RN can delegate unplanned time away if the RN has trained the ULP and determined the ULP is competent to follow the procedures for giving medication to clients. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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03090	Continued From page 22	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, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all resident, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 30, 2023, at 9:00 a.m., the surveyor entered the facility. No signage of electronic monitoring was posted on the entry door as required. On May 30, 2023, at 9:50 a.m., registered nurse (RN)-A, who is also the owner and the licensed assisted living director (LALD), confirmed the facility did not have the electronic monitoring	03090		

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03090	Continued From page 23 signage posted as required. The licensee did not provide an Electronic Monitoring policy when requested. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *05/30/23*
Time: 12:36:04
Report: 1004231038

Food and Beverage Establishment Inspection Report

Location:
Shelter Arm LLC
9444 Fallgold Parkway N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0041265
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

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.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

ESTABLISHMENT DOES NOT USE AN EMPLOYEE ILLNESS LOG. ENSURE ALL EMPLOYEE REPORTS OF GASTROINTESTINAL AND ILLNESS SYMPTOMS INDICATIVE OF ILLNESSES THAT CAN BE SPREAD THROUGH FOOD ARE RECORDED ON ILLNESS LOG, INCLUDING DATE EMPLOYEE RETURNED TO WORK.

Comply By: 05/30/23

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

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

DISH MACHINE IS NOT REACHING A MINIMUM OF 160*F UTENSIL SURFACE TEMPERATURE FOR SANITIZING. SERVICE MACHINE IMMEDIATELY AND USE A CHEMICAL SANITIZER UNTIL MACHINE CAN BE REPAIRED.

Comply By: 05/30/23

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.

NO IRREVERSIBLE TEMPERATURE INDICATOR(S) ON SITE TO USE TO VERIFY THE UTENSIL SURFACE TEMPERATURE FOR THE HIGH TEMPERATURE SANITIZING DISH MACHINE. PROVIDE AND USE FREQUENTLY TO ENSURE A TEMPERATURE OF 160*f OR ABOVE IS REACHED FOR SANITIZING.

Comply By: 05/30/23

2-100 Supervision

2-102.12AMN

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

NO STATE CERTIFIED FOOD PROTECTION MANAGER. EMPLOYEE HAS TAKEN FOOD SAFETY COURSE BUT DID NOT APPLY WITH THE STATE. INFORMATION PROVIDED TO PERSON IN CHARGE.

Comply By: 05/30/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

DISH MACHINE IS UNABLE TO PROVIDE A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160*F FOR SANITIZING. REPAIR/ADJUST MACHINE OR REPLACE TO ENSURE A MINIMUM UTENSIL SURFACE TEMPERATURE OF 160*F IS REACHED TO SANITIZE ALL DISHES.

Comply By: 06/05/23

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: REFIGERATOR
Violation Issued: No

Process/Item: RICE
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY CAROL MORONEY.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG (LOG PROVIDED TO PERSON IN CHARGE)
-HANDWASHING
-SANITIZER USE AND TEST KITS
-HIGH TEMPERATURE SANITIZING DISH MACHINE VERIFICATION (THERMO-LABELS LEFT ON SITE FOR USE DURING INSPECTION)
-MANUAL SANITIZING USING CHLORINE BLEACH
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

*REPORT WAS DISCUSSED WITH THE STAFF ON SITE, EMMANUEL, AND WITH THE NURSE EVALUATOR, CAROL.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*FLOORS ARE SEALED WOOD AND CEILING AND WALLS ARE PAINTED SHEETROCK. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. 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

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 1004231038 of 05/30/23.

Certified Food Protection Manager: NONE

Certification Number: _____ Expires: / /

Signed: _____

EMMANUEL

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
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