Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 10, 2024

Licensee
Caring Angels Health Care Inc
7642 Jasmine Avenue South
Cottage Grove, MN 55016

RE: Project Number(s) SL39620015

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 April 10, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

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

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.

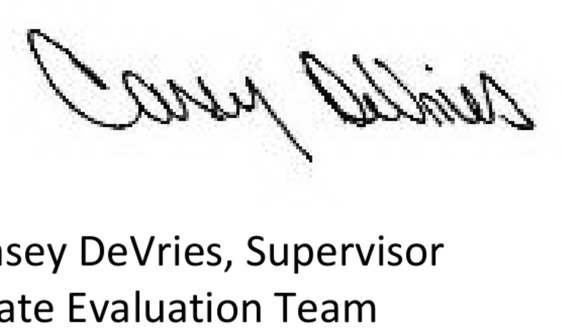
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39620	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING ANGELS HEALTH CARE INC	7642 JASMINE AVENUE SOUTH COTTAGE GROVE, MN 55016

(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: SL39620015-0 On April 8, 2024, through April 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident: one receiving services under the provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 460 SS=C	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 8, 2024, at 10:19 a.m., during a facility tour, the surveyor observed a split-level home and did not observe call lights, call pendants, or	0 460		

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0 460	Continued From page 2 bells located in the rooms of the residents or in the common areas. On April 8, 2023, at 12:17 p.m., owner (O)-B stated their one current resident was independent and, "can do everything". O-B stated they were aware of the requirement to provide a means to request assistance. On April 9, 2024, at 11:25 licensed assisted living director (LALD)-A stated they were aware of requirement of providing a means for residents to request assistance. LALD-A stated R1 used his own personal cellular phone to request assistance, R1 declined a means to request assistance from the licensee but was not documented by the registered nurse (RN). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;	0 470		

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0 470	Continued From page 3 (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 interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 April 8, 2024, at 9:41 a.m., during the entrance conference owner (O)-B stated one unlicensed personnel (ULP) worked per shift and	0 470		

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0 470	Continued From page 4 the shift schedule was 6:00 a.m., until 2:00 p.m., 2:00 p.m., until 10:00 p.m., and 10:00 p.m., until 6:00 a.m. O-A stated the registered nurse (RN) worked for the licensee Monday through Thursday 9:00 a.m., until 1:00 p.m., and on call 24 hours per day. O-A stated the staffing plan was developed by the clinical nurse supervisor (CNS) and evaluated twice a year. On April 8, 2024, at 1:58 p.m., CNS-C stated a staffing plan was not created as the licensee only had one resident. On April 8, 2024, at 7:38 p.m., the licensee provided an undated document titled Staffing Plan. The staffing Plan lacked the following information: -evaluation performed twice a year by a RN, and; -ensured sufficient staffing at all times to meet the scheduled and reasonably unscheduled needs of each resident as required by the resident's assessment. On April 9, 2024, at 11:21 a.m., licensed assisted living director (LALD)-A stated they were aware of the staffing plan requirement and the RN was responsible for creating the staffing plan and evaluating it twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

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0 480	Continued From page 5 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) 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	0 485		

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0 485	Continued From page 6 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; 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 require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. 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 April 8, 2024, at 1:44 p.m., owner (O)-B provided the surveyor with a blank contact and stated it was used for all residents who resided at the facility.	0 485		

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0 485	Continued From page 7 The licensee's Assisted Living Contract page 13 included: "This Assisted Living Facility offers all the following (included in the Month Base Fee): -at least three meals daily with snacks available seven (7) days per week." The contract did not include language to inform residents they could choose which meals to purchase with their service plan. On April 8, 2024, at 2:21 p.m., O-B stated served food to the residents is included in the monthly fee, and they took the contract from an outside consultant company. On April 9, 2024, at 11:28 a.m., licensed assisted living director (LALD)-A stated they were aware served food was included in the monthly fee. LALD-A stated it depended on how the contract was viewed and the licensee does not include a food fee in the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number	0 640		

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0 640	Continued From page 8 for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 April 8, 2024, at 10:30 a.m., during a facility tour of the split-level home, in the common area of the lower level, the surveyor observed a landline telephone next to the fireplace. There was no 911 posted near the landline telephone. There was no 911 posting throughout the facility. On April 8, 2024, at 12:00 p.m., unlicensed personnel (ULP)-E stated the landline telephone was used by residents. On April 8, 2024, at 12:18 p.m., owner (O)-B stated the landline telephone would be used in an emergency, and they were unaware of the	0 640		

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0 640	Continued From page 9 required posting. On April 9, 2024, at 11:34 a.m., licensed assisted living director (LALD)-A stated they were aware of the required posting for landline telephones and believed the 911 posting was upstairs. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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	0 680		

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0 680	Continued From page 10 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: -emerging infectious diseases (EIDs); -emergency plan (EP) program for patient population; -process for EP collaboration with local, tribal, regional, State and Federal; -substance needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - emergency official contact information; - methods for sharing information;	0 680		

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0 680	Continued From page 11 - sharing information on occupancy and need, and; - long-term care (LTC) family notifications. On April 9, 2024, at 11:36 a.m., licensed assisted living director (LALD)-A stated they were aware of the required content for the EPP, and the believed the current EPP met the statutory requirements. The licensee's undated MN Statute 144A.4791, Subd 12 Emergency Management policy indicated the assisted living facility (ALF) will have a plan in place to ensure the safety and well-being of residents and employees during an emergency that disrupts facility services. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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, including walls, floors, ceiling, all furnishings,	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39620	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING ANGELS HEALTH CARE INC	7642 JASMINE AVENUE SOUTH COTTAGE GROVE, MN 55016

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0 800	Continued From page 12 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 8, 2024, at 10:30 a.m., survey staff toured the facility with owner (O)-B. It was observed that the residents were using a paint can as an ashtray and the facility did not have a non-combustible ashtray. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if cigarettes were not completely extinguished before discarding them. During interview on April 9, 2024, at 11:00 a.m., O-B stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 13 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01470		

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01470	Continued From page 14 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of three employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: CNS-C was hired on May 1, 2023, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C's employee record lacked evidence of	01470		

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	39620	A. BUILDING: _____ B. WING _____	04/10/2024

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01470	Continued From page 15 orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; and -Principles of person-centered planning/service delivery. On April 9, 2024, at 10:03 a.m., CNS-C stated the licensee gave them assisted living facility polices and rules to review and they did not recall orientation training on Minnesota Statutes 144G. CNS-C stated they were unaware of the required training and had read statutes online from the Minnesota Department of Health (MDH) website. On April 9, 2024, at 11:42 a.m., licensed assisted living director (LALD)-A stated all staff were required to have the Minnesota Statute 144G training and believed the required orientation training was part of homecare training the CNS-C had completed at a different employment. The licensees undated MN Statute 144G.63, Subd 1 and 2 Facility Employee Orientation policy indicated all employees will complete orientation topics required by Minnesota statutes and rules for assisted living.	01470		

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	39620	A. BUILDING: _____ B. WING _____	04/10/2024

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01470	Continued From page 16 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the	01530		

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	39620	A. BUILDING: _____ B. WING _____	04/10/2024

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01530	Continued From page 17 licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of three employees (clinical nurse supervisor)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Clinical nurse supervisor (CNS)-C was hired on May 1, 2023, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C employee file lacked the following required content: -dementia training required for all direct care staff and supervisors, and; -initial 8 hours of dementia care training within 120 hours. On April 9, 2024, at 10:03 a.m., CNS-C stated the licensee gave them assisted living facility (ALF) polices and rules to review and they did not recall orientation training on Minnesota Statute 144G. CNS-C stated they were unaware of the required training and had read statutes online from the Minnesota Department of Health (MDH) website. On April 9, 2024, at 11:42 a.m., licensed assisted living director (LALD)-A stated all staff were required to have the statute 144G training and	01530		

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	39620	A. BUILDING: _____ B. WING _____	04/10/2024

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01530	Continued From page 18 believed the required orientation training was part of homecare training the CNS-C had completed at a different company. The licensees undated MN Statute 144G.63, Subd 1 and 2 Facility Employee Orientation policyindicated all employees will have completed orientation topics required by Minnesota statutes and rules for assisted living. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	01730		

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	39620	A. BUILDING: _____ B. WING _____	04/10/2024

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01730	Continued From page 19 tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an widespread 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:	01730		

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01730	Continued From page 20 R1 was admitted to the licensee on December 16, 2023, and began receiving assisted living services. R1's diagnoses include schizophrenia (hallucinations, disorganized speech, trouble with thinking and lack of motivation), major depression, diabetes, neuropathy (generalized nerve pain), paranoia, and anorexia (eating disorder). R1's [licensee] Assisted Living Service Plan indicated R1 received assistance with medication setup, medication administration, medication education, medication reordering, storage of medications, behavior management, vital signs (VS), assist with baths and grooming, assist with cleaning room, meal preparation, infection control education, and monitor for fall prevention. R1's Medication Administration Record (MAR) dated April 1, 2024, through April 8, 2024 indicated R1 received the following medications; Cyanocobalamin (Vitamin B-12) 100 milligram (mg) daily at bedtime, doxycycline hyclate 100 mg morning and bedtime, duloxetine 60 mg morning and bedtime, metformin 100 mg evening, rosuvastatin 10 mg evening, Ammonium Lactate 12 percent (%) external lotion apply lotion topically twice daily to directed areas in the morning, Paliperidone 234 mg Invega 1.5 milliliters (ml) every 30 days, Turmeric Curcumin 1000 mg at bedtime, Vitamin C 500 mg at bedtime, Seneson-S 8.6-50 mg as needed, and Lactobacillus Acidophilus 0.05 mg morning. On April 9, 2024, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-E administer the following medications to R1: doxycycline 100 mg, duloxetine 60 mg, and	01730		

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	39620	A. BUILDING: _____ B. WING _____	04/10/2024

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01730	Continued From page 21 Lactobacillus Acidophilus 0.05 mg. ULP-E documented doxycycline 100 mg, duloxetine 60 mg, Lactobacillus Acidophilus 0.05 mg and Ammonium Lactate 12 percent (%) external lotion as administered to R1. The surveyor did not observe Ammonium Lactate 12 percent (%) external lotion administered to R1. On April 9, 2024, at 7:36 a.m., the surveyor observed the Ammonium Lactate 12 percent (%) external lotion in R1's room. R1 stated they applied the lotion to both feet after a shower. R1's initial assessment dated December 16, 2023, and 90-day assessment dated March 15, 2024, lacked documentation the resident could self-administer medications. On April 9, 2024, at 7:46 a.m., clinical nurse supervisor (CNS)-C stated when R1 was first admitted to the assisted living facility (ALF), R1 self-administrated their own medications. CNS-C stated R1 was not capable of self-administering medications, so the licensee began medication management for R1. CNS stated R1 refused to give the Ammonium Lactate 12 percent (%) external lotion to staff. On April 9, 2024, at 11:46, a.m., licensed assisted living director (LALD)-A stated the RN should have included in the assessment if a resident can store and self-administer medications. LALD-A stated they would consult with R1's medical prescriber to determine if R1 can self-administer the medication. The licensee's undated MN Statue 144G.71 subd. 3 and 5 Individualized Medication Management Plan and Records policy indicated	01730		

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	39620	A. BUILDING: _____ B. WING _____	04/10/2024

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01730	Continued From page 22 medications would be stored, based on the resident's needs, risks of diversion, and consistent with the manufacturer's directions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01810 SS=F	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure over-the-counter (OTC) drugs were up to date and stored as appropriate for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01810	Continued From page 23 The findings include: On April 8, 2024, at 10:42 a.m., the surveyor observed R1's locked medication cabinet which contained a Zinc 50 milligram (mg) bottle that expired November 2023. On April 8, 2024, at 10:42 a.m., owner (O)-B stated the registered nurse (RN) was responsible for removing expired medications, and the medication may have been discontinued. On April 8, 2024, at 1:29 p.m., clinical nurse supervisor (CNS)-C stated they were responsible for removing expired medications. CNS-C stated it was an oversight and the medication was left in the drawer, "that's the only place to have medications". On April 9, 2024, at 11:52 a.m., licensed assisted living director (LALD)-A stated R1 brought the medication from their previous assisted living facility, and the clinical nurse supervisor was responsible for removing expired medications. LALD-A stated they were unsure why the medication was not removed from the medication cabinet. The licensee's undated Medication Management Services policy indicated the RN was responsible for implementation of the ALF medication management policies and procedure, for the disposal of medications when needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39620	A. BUILDING: _____ B. WING _____	04/10/2024

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01820	Continued From page 24	01820		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain current medication prescriptions for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an widespread 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 was admitted to the licensee on December 16, 2023, and began receiving assisted living services. R1's diagnoses included schizophrenia (hallucinations, disorganized speech, trouble with thinking and lack of motivation), major depression, diabetes, neuropathy (generalized nerve pain), paranoia, and anorexia (eating disorder). R1's [licensee] Assisted Living Service Plan	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39620	A. BUILDING: _____ B. WING _____	04/10/2024

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CARING ANGELS HEALTH CARE INC	7642 JASMINE AVENUE SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 25 indicated R1 received assistance with medication setup, medication administration, medication education, medication reordering, storage of medications, behavior management, vital signs (VS), assist with baths and grooming, assist with cleaning room, meal preparation, infection control education, and monitor for fall prevention. R1's Medication Administration Record (MAR) dated April 1, 2024, through April 8, 2024, indicated R1 received the following medications; Cyanocobalamin (Vitamin B-12) 100 milligram (mg) daily at bedtime, doxycycline hyclate 100 mg morning and bedtime, duloxetine 60 mg morning and bedtime, metformin 100 mg evening, rosuvastatin 10 mg evening, Ammonium Lactate 12 percent (%) external lotion apply lotion topically twice daily to directed areas in the morning, Paliperidone 234 mg Invega 1.5 milliliters (ml) every 30 days, Turmeric Curcumin 1000 mg at bedtime, Vitamin C 500 mg at bedtime, Seneson-S 8.6-50 mg as needed, and Lactobacillus Acidophilus 0.05 mg morning. On April 9, 2024, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-E administer the following medications to R1: doxycycline 100 mg, duloxetine 60 mg, and Lactobacillus Acidophilus 0.05 mg. R1's record lacked a current written or electronically recorded prescription for the medications listed above. On April 8, 2024, at 2:03 p.m., clinical nurse supervisor (CNS)-C stated they used the after-visit summary (AVS) as signed orders for prescribed medications, and they were unaware the AVS required a signature from the medical provider. The document lacked an electronic or	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39620	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING ANGELS HEALTH CARE INC	7642 JASMINE AVENUE SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 26 physical signature from a medical prescriber. On April 9, 2024, at 11:46 p.m., licensed assisted living director (LALD)-A stated there should be signed orders from a medical prescriber for all prescribed medications. LALD-A stated the registered nurse (RN) was responsible for obtaining signed orders from a medical prescriber. The licensee's undated Medication Prescription and Refills policy indicated when medications are prescribed to residents, the RN will request a copy of the signed prescription order from the provider. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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

Type: Full
Date: *04/08/24*
Time: 11:41:16
Report: 1004241090

Food and Beverage Establishment Inspection Report

Location:
Caring Angels Health Care Inc
7621 14th Ave S
Cottage Grove, MN55016
Washington County, 82

Establishment Info:
ID #: 0042568
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(2) ***** Priority 1 *****

MN Rule 4626.0235A(2) Separate types of raw animal foods from other raw animal foods during storage, preparation and display based on cook temperature.

RAW GROUND TURKEY FOUND STORED OVER SHELL EGGS IN THE REFRIGERATOR. ENSURE RAW ANIMAL PRODUCTS ARE STORED IN THE ORDER OF THEIR COOK TEMPERATURE. *DISCUSSED STORAGE ORDER REQUIREMENTS WITH OPERATOR.

Comply By: 04/08/24

3-500C Microbial Control: date marking

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

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

NO DATE MARKING ON OPENED PACKAGES OF DELI MEAT. ENSURE ALL OPENED PACKAGES OF TCS ITEMS ARE CLEARLY DATE MARKED TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS OF OPENING. *DISCUSSED DATE MARKING PROCEDURES WITH OPERATOR.

Comply By: 04/08/24

Type: Full
Date: *04/08/24*
Time: 11:41:16
Report: 1004241090
Caring Angels Health Care Inc

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

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

CFPM CERTIFICATION IS BEING USED AT MORE THAN ONE LOCATION. EACH LICENSED FACILITY IS REQUIRED TO HAVE THEIR OWN CFPM.

Comply By: 04/22/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 165 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: DELI TURKEY
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

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

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-PREVENTING BAREHAND CONTACT
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-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
-LOGS
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE OPERATOR, TONY, AND WITH THE NURSE EVALUATOR, KEITH.

*FLOORS ARE VINYL, WALLS ARE PAINTED DRYWALL AND CEILING IS "POPCORN"

TEXTURE. COUNTERTOPS ARE SEALED STONE AND CABINETS ARE PAINTED 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.

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

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

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 1004241090 of 04/08/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____

TONY OSHODI
OPERATOR

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us