Electronically Delivered

September 3, 2024

Licensee
Minn Care Home Health
7215 Fremont Avenue North
Brooklyn Center, MN  55430

RE:  Project Number(s) SL37270015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 2, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

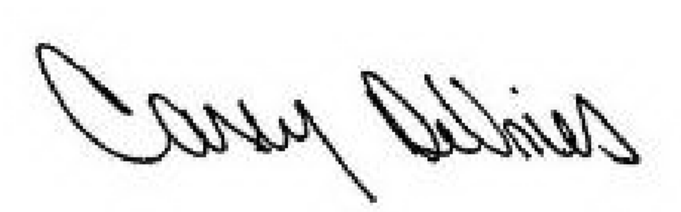
To submit a reconsideration request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37270 | A. BUILDING: _____ B. WING _____ | 08/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MINN CARE HOME HEALTH | 7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL37270015-0<br><br>On July 29, 2024, through, August 2, 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 were two resident(s); two receiving services under the provider's 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 evaluators ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for | 0 470 | | |

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| 0 470 | Continued From page 1<br><br>determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(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<br>(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;<br>(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:<br>(i) awake;<br>(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;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse (RN) at least twice a year (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 470 | | |

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| 0 470 | Continued From page 2<br><br>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).<br><br>The findings include:<br><br>On August 1, 2024, at 12:18 p.m., licensed assisted living director (LALD)-B stated the licensee did not have an official written staffing plan, and stated LALD-A was typically in charge of ensuring appropriate staffing levels and creation of schedules.<br><br>On August 2, 2024, at 9:44 a.m., clinical nurse supervisor (CNS)-E stated LALD-A was responsible for development of the staffing plan. CNS-E stated they would make recommendations on staffing levels but were not actively involved in the development of staffing levels. CNS-E stated they were not aware the clinical nurse supervisor was responsible for the development of the licensee's staffing plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, | 0 480 | | |

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| 0 480 | Continued From page 3<br>chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>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).<br>The findings include:<br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 500 SS=F | 144G.41 Subd. 2 Policies and procedures<br><br>Each assisted living facility must have policies and procedures in place to address the following and keep them current:<br>(1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;<br>(2) conducting and handling background studies on employees;<br>(3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;<br>(4) handling complaints regarding staff or | 0 500 | | |

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| 0 500 | Continued From page 4<br><br>services provided by staff;<br>(5) conducting initial evaluations of residents' needs and the providers' ability to provide those services;<br>(6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;<br>(7) orientation to and implementation of the assisted living bill of rights;<br>(8) infection control practices;<br>(9) reminders for medications, treatments, or exercises, if provided;<br>(10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;<br>(11) ensuring that nurses and licensed health professionals have current and valid licenses to practice;<br>(12) medication and treatment management;<br>(13) delegation of tasks by registered nurses or licensed health professionals;<br>(14) supervision of registered nurses and licensed health professionals; and<br>(15) supervision of unlicensed personnel performing delegated tasks.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 500 | | |

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| 0 500 | Continued From page 5<br><br>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).<br><br>The findings include:<br><br>On July 29, 2024, at 8:25 a.m., the surveyor emailed the licensee that an onsite assisted living facility with dementia care survey would be initiated on July 29, 2024, at approximately 10:00 a.m. The email indicated the licensee's policies and procedures would need to be available for review.<br><br>The licensee failed to provide the following policies and procedures during or after the survey process:<br>- medication management plans; and<br>- staffing plans.<br><br>The licensee provided policies that included language for Comprehensive Home Care providers found in MN Statutes 144A, not language for Assisted Living providers found in MN Statutes 144G for the following policies:<br>- Assessment, Monitoring, and Reassessment Policy dated January 2020;<br>- 4.09 Service Plans policy, dated January 1, 2020;<br>- 5.13 Storage of Medications policy date January 1, 2020; and<br>- 5.17 Disposal of Medication date January 1, 2020.<br><br>On August 1, 2024, at 1:17 p.m., licensed assisted living director (LALD)-A sent an email to | 0 500 | | |

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| 0 500 | Continued From page 6<br><br>the surveyor which indicated the licensee did not have a specific policy on medication management plans.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 500 | | |
| 0 570 SS=C | 144G.42 Subdivision 1 Display of license<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance as required.<br><br>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 the residents).<br><br>The findings include:<br><br>On July 29, 2024, at approximately 10:00 a.m., upon entrance into the facility, the surveyor observed the licensee had photocopy of the licensee's expired license posted on the wall.<br><br>On July 31, 2024, at approximately 3:45 p.m., | 0 570 | | |

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| 0 570 | Continued From page 7<br><br>LALD-A stated they were unaware the licensee was required to post the original license near the entrance of the facility.<br><br>The licensee's unnamed and undated required posting checklist indicated that the original and current assisted living license was to be posted at the main entrance of the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 570 | | |
| 0 630 SS=F | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2).<br><br>This practice resulted in a level two violation (a | 0 630 | | |

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| 0 630 | Continued From page 8<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 was admitted to the licensee on July 31, 2023, and began receiving assisted living services.<br><br>R1's diagnoses included illness unspecified (primary), insomnia, essential hypertension, hypothyroidism, constipation acute embolism and thrombosis of deep veins of upper extremities, and major depressive disorder.<br><br>R1's Service Plan -Waiver, dated February 8, 2023, indicated R1 received assistance with ambulation, appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, assistance with managing finances, medication administration, shopping assistance, and transfer assistance.<br><br>R1's IAPP dated January 31, 2024, indicated R1 was at risk of being abused by others. R1's IAPP contained no information regarding statements of the specific measures to be taken to minimize the risk of abuse.<br><br>R2<br>R2 was admitted to the licensee on August 4, 2022, and began receiving assisted living services.<br><br>R2's diagnoses included bipolar disorder, | 0 630 | | |

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| 0 630 | Continued From page 9<br><br>dorsalgia (back or spine pain, including low back, mid back, and sciatic pain), major depressive disorder, and emphysema.<br><br>R2's Service Plan -Waiver, dated August 4, 2022, indicated R2 received assistance with appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, assistance with managing finances, meal assistance, medication administration, positioning, safety checks, shopping assistance, and assistance with transfers.<br><br>R2's IAPP dated January 31, 2024, indicated R2 was at risk of being abused by others. R2's IAPP contained no information regarding statements of the specific measures to be taken to minimize the risk of abuse.<br><br>On July 31, 2024, at 2:37 p.m., clinical nurse supervisor (CNS)-E stated they were responsible for completing IAPP's for residents, and stated they were not aware they had not documented the IAPP appropriately.<br><br>The licensee's undated Individual Abuse Prevention Plan (IAPP) policy indicated the plan shall include a statement of measures that will be taken to minimize the risk of abuse to the vulnerable adult when the individual assessment required in section 626.557, subdivision 14, paragraph (b), indicates the need for measures in addition to the specific measures identified in the program abuse prevention plan. The measures shall include the specific actions the program will take to minimize the risk of abuse within the scope of the licensed services and will identify referrals made when the vulnerable adult is susceptible to abuse outside the scope or control of the licensed services. | 0 630 | | |

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| 0 630 | Continued From page 10<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a written emergency | 0 680 | | |

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| MINN CARE HOME HEALTH | 7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
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| 0 680 | Continued From page 11<br><br>preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>The licensee's written emergency disaster preparedness plan lacked evidence of the following required content:<br>- Annual review of the Emergency Preparedness Plan;<br>- Quarterly review of missing resident policy;<br>- A written risk assessment utilizing an all-hazards approach;<br>- Categorization of probable risks by likelihood of occurrence;<br>- Written strategies addressing facility and community-based risks;<br>- Missing Resident Plan;<br>- Policies and procedures to identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care;<br>- Policies and procedures to identify which staff would assume specific roles in another's absence through succession planning and delegation of authority;<br>- Annual review and/or updates of policies;<br>- Process for Collaboration;<br>- process for cooperation and collaboration | 0 680 | | |

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| 0 680 | Continued From page 12<br>with local, tribal, regional, State and Federal EP to maintain integrated response;<br>- Policies and procedures for subsistence needs for staff and residents;<br>- Policies and procedures to address needs for staff and residents whether evacuated or sheltered in place;<br>- Policies and procedures for food, water, medical supplies, and pharmaceutical supplies;<br>- Policies and procedures for the safe/sanitary storage of provisions;<br>- Policies and procedures for tracking staff and patients;<br>- Policies and procedures for sheltering in place;<br>- Policies and procedures for medical documents;<br>- Must develop a policy and procedure to maintain medical documentation the preserves resident information, protects confidentiality, and secures/maintains the availability of records;<br>- Roles under wavier declared by secretary;<br>- Policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver;<br>- Development of Communication Plan;<br>- Names and contact information of staff, entities providing services under agreement, residents physicians, other facilities, and volunteers;<br>- Emergency officials contact information;<br>- Policies and procedures including primary and alternate means of communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies;<br>- Methods for sharing information;<br>- Sharing information on occupancy needs;<br>- Long term care family notifications;<br>- Emergency prep testing to include a disaster drill;<br>- Emergency prep training program; and<br>- Emergency prep testing requirements. | 0 680 | | |

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| 0 680 | Continued From page 13<br><br>On July 29, 2024, at 1:44 p.m., licensed assisted living director (LALD)-A stated they were under the belief that their current Emergency Preparedness Plan (EPP) contained all required content and were unaware of the deficits. LALD-A stated they had worked a provider organization in the past on their current EPP.<br><br>The licensee's Disaster Planning and Emergency Preparedness Plan policy dated October 1, 2021, indicated [licensee] will have in place a written emergency and disaster plan, signage, directions, training, and drills to facilitate the management of tenant's care and services in response to a natural disaster or other emergencies.<br><br>No further information was provided.<br><br>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<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is | 0 780 | | |

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| 0 780 | Continued From page 14<br><br>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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.<br><br>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).<br><br>The findings include:<br><br>During the facility tour on August 1, 2024, with the licensed assistant living director (LALD)-B, between 10:30 a.m. and 12:00 p.m. the following deficient conditions were observed:<br><br>The surveyor observed when the smoke alarms were push button tested by the LALD-B, some of the alarms did not operate. All the smoke alarms | 0 780 | | |

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| 0 780 | Continued From page 15<br>in the residence where not interconnected.<br><br>The surveyor explained to the LALD-B, that 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.<br><br>The surveyor observed when the smoke alarms were removed by the LALD-B, the smoke alarms in the lower-level resident room 5 and outside resident room 5 were battery operated and there were wires present for a 120-volt smoke alarm. Resident room 4 lower-level had a 120 volt smoke alarm present but was not interconnected with the rest of the smoke alarms in the residence.<br><br>The surveyor explained to the LALD-B, that all smoke alarms shall comply with the Minnesota State Fire Code which states all smoke alarms shall be replaced with like type alarms. These 3 smoke alarms shall be 120-volt, battery backup and interconnected to the rest of the smoke alarms in the residence. The rest of the smoke alarms may be battery operated.<br><br>The deficient condition was visually verified by the LALD-B accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, | 0 800 | | |

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| 0 800 | Continued From page 16<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>During the facility tour on August 1, 2024, with the licensed assistant living director (LALD)-B, between 10:30 a.m. and 12:00 p.m. the following facility hazards and disrepair were observed:<br><br>GARAGE/RESIDENCE DOOR:<br><br>The surveyor observed a wood hollow core door between the garage and the residence.<br><br>The surveyor explained to LALD-B, that the door between the garage and the residence is required | 0 800 | | |

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| 0 800 | Continued From page 17<br>to be one-hour fire-resistant construction, openings shall be protected by listed fire doors, insulated steel doors or 1 3/8-inch thick or 1 3/4-inch thick solid wood doors.<br><br>PROPANE CYLINDER STORAGE:<br><br>The surveyor observed a 20-pound propane cylinder in the garage.<br><br>The surveyor explained to LALD-B that all propane cylinders shall be stored outside the residence including outside of the garage.<br><br>The deficient conditions were visually verified by the LALD-B accompanying on the tour.<br><br>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<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation | 0 810 | | |

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| 0 810 | Continued From page 18<br><br>plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>A record review and interview were conducted on August 1, 2024, at approximately 11:30 a.m. with | 0 810 | | |

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| 0 810 | Continued From page 19<br><br>the licensed assistant living director (LALD)-B on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN:<br><br>The fire safety and evacuation plan failed to include the following:<br><br>The fire safety and evacuation plan included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.<br><br>The fire safety and evacuation plan did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.<br><br>The fire safety and evacuation plan included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents | 0 810 | | |

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| 0 810 | Continued From page 20<br><br>during evacuation nor did it include instructions for staff to follow in case of relocation.<br><br>TRAINING:<br><br>Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-B was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan.<br><br>Record review indicated the licensee failed to provide training to employees on the fire safety and evacuation plan upon hire and at least twice per year. LALD-B was unable to provide documentation showing any training provided or training scheduled for a future date.<br><br>During an interview on August 1, 2024, LALD-B stated they will start to complete the required training.<br><br>DRILLS:<br><br>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documentation indicated that one drill was completed on 5/23/24.<br><br>During an interview on August 1, 2024, LALD-B stated they will start doing the evacuation drills and understood the requirements.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |

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| 01610 | Continued From page 21 | 01610 | | |
| 01610 SS=D | 144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of two residents (R1) on or before the admission date.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). | 01610 | | |

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| 01610 | Continued From page 22<br>The findings include:<br><br>R1 was admitted to the licensee on July 31, 2023, and began receiving assisted living services.<br><br>R1's diagnoses included illness unspecified (primary), insomnia, essential hypertension, hypothyroidism, constipation acute embolism and thrombosis of deep veins of upper extremities, and major depressive disorder.<br><br>R1's Service Plan -Waiver, dated February 8, 2023, which was completed at an affiliated sister facility, indicated R1 received assistance with ambulation, appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, assistance with managing finances, medication administration, shopping assistance, and transfer assistance.<br><br>R1's record contained an admission assessment dated February 24, 2023. This admission assessment was completed at an affiliated facility prior to R1 moving into the current facility.<br><br>On July 30, 2024, 10:53 a.m., licensed assisted living director (LALD)-A stated R1 had been transferred from an affiliated facility, and the admission assessment dated February 24, 2023, was the only admission assessment on file for R1. LALD-A stated they were not aware they were not allowed to treat residents moving from an affiliated facility as a transfer, and they were required to treat these types of moves as a discharge followed by a new admission.<br><br>On July 31, 2024, at 2:37 p.m., clinical nurse supervisor (CNS)-E stated R1 was transferred from an affiliated facility, and an admission assessment had not been completed due the | 01610 | | |

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| 01610 | Continued From page 23<br><br>residents move from an affiliated facility being treated as a transfer. CNS-E stated they were not aware the move should have been treated as a discharge followed by a new admission. CNS-E stated they believed this was missed due to lack of knowledge on the process.<br><br>The licensee's Assessment, Monitoring and Reassessment Policy dated January 2020 indicated that when the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. This assessment must be completed within five days after initiation of home care services. The licensee's policy included language for Comprehensive Home Care providers found in MN Statutes 144A, not language for Assisted Living providers found in MN Statutes 144G.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01610 | | |
| 01620 SS=F | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs | 01620 | | |

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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 |
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| 01620 | Continued From page 24<br><br>and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 14 calendar days from the initiation of services, for two of two residents (R1, R2) and failed to ensure the RN conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R1, R2).<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 was admitted to the licensee on July 31, 2023, | 01620 | | |

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| 01620 | Continued From page 25<br>and began receiving assisted living services.<br><br>R1's diagnoses included illness unspecified (primary), insomnia, essential hypertension, hypothyroidism, constipation acute embolism and thrombosis of deep veins of upper extremities, and major depressive disorder.<br><br>R1's Service Plan -Waiver, dated February 8, 2023, which was completed at an affiliated sister facility, indicated R1 received assistance with ambulation, appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, assistance with managing finances, medication administration, shopping assistance, and transfer assistance.<br><br>R1's record lacked an assessment occurring 14 days after the initiation of services. Additionally R1's record contained ongoing 90 day assessments occurring October 28, 2023, and January 31, 2023, which indicated that 95 days had lapsed between assessment dates.<br><br>R2<br>R2 was admitted to the licensee on August 4, 2022, and began receiving assisted living services.<br><br>R2's diagnoses included bipolar disorder, dorsalgia (back or spine pain, including low back, mid back, and sciatic pain), major depressive disorder, and emphysema.<br><br>R2's Service Plan -Waiver, dated August 4, 2022, indicated R2 received assistance with appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, assistance with managing finances, meal assistance, medication administration, | 01620 | | |

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| 01620 | Continued From page 26<br><br>positioning, safety checks, shopping assistance, and assistance with transfers.<br><br>R2's 14-day assessment occurred on August 28, 2022, which indicated 24 days had passed since R2's admission assessment. R2's record contained ongoing 90 day assessments which occurred on August 2, 2023, and November 2, 2023, indicating 92 days had lapsed between assessment dates. R2's next assessment after November 2, 2023, was February 2, 2024, which indicated 92 days had lapsed between assessment dates. Additionally, R2's next assessment after February 2, 2024, was May 3, 2024, which indicated 91 had lapsed between assessment dates.<br><br>On July 31, 2024, at 2:37 p.m., clinical nurse supervisor (CNS)-E stated that the expectation was to complete an assessment 14 days after admission, and then every 90 days afterwards unless there was a change in condition. CNS-E stated on some of the occasions in which assessment dates were delayed, they had arrived on the due date of the assessment to find that the resident was not in the facility at the time of assessment.<br><br>The licensee's Assessment, Monitoring, and Reassessment Policy dated January 2020, indicated client (resident) monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services, and ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The licensee's policy included language for Comprehensive Home Care providers found in MN Statutes 144A, not | 01620 | | |

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| 01620 | Continued From page 27<br>language for Assisted Living providers found in MN Statutes 144G.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to complete a service plan within 14 days of admission for one of two residents | 01640 | | |

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| 01640 | Continued From page 28<br>(R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 was admitted to the licensee on July 31, 2023, and began receiving assisted living services.<br><br>R1's diagnoses included illness unspecified (primary), insomnia, essential hypertension, hypothyroidism, constipation acute embolism and thrombosis of deep veins of upper extremities and major depressive disorder.<br><br>R1's Service Plan -Waiver dated February 8, 2023, indicated R1 received assistance with ambulation, appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, assistance with managing finances, medication administration, shopping assistance, and transfer assistance.<br><br>On July 30, 2024, at 10:53 a.m., licensed assisted living director (LALD)-A stated R1's signed service plan had the date listed that R1 was admitted to an affiliated sister facility. LALD-A stated R1 had moved to the current facility on July 31, 2023. LALD-A stated they were not aware that a new service plan would need to be developed as R1 was still receiving services from the same business. | 01640 | | |

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| 01640 | Continued From page 29<br><br>On July 31, 2024, at 2:37 p.m., clinical nurse supervisor (CNS)-E stated there was no new service plan developed for R1 due lack of knowledge on the issue. CNS-E stated, "I thought that because they are the same business, I assumed the service plan would be able to be transferred."<br><br>The licensee's 4.09 Service Plans policy, dated January 1, 2020, indicated that the home care provider nshall finalize a written service plan within 14 days after the date that home care services are first provided to a client (resident). The licensee's policy included language for Comprehensive Home Care providers found in MN Statutes 144A, not language for Assisted Living providers found in MN Statutes 144G.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01710 SS=D | 144G.71 Subd. 3 Individualized medication monitoring and reas<br><br>The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a | 01710 | | |

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| 01710 | Continued From page 30<br><br>re-assessment when there was change in the resident's medications to evaluate potential side effects or drug interactions for a resident's non-prescribed drug use.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 was admitted to the licensee on July 31, 2023, and began receiving assisted living services.<br><br>R1's diagnoses included illness unspecified (primary), insomnia, essential hypertension, hypothyroidism, constipation acute embolism and thrombosis of deep veins of upper extremities, and major depressive disorder.<br><br>R1's Service Plan -Waiver dated February 8, 2023, indicated R1 received assistance with ambulation, appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, assistance with managing finances, medication administration, shopping assistance, and transfer assistance.<br><br>R1's medication management plan, dated January 31, 2024, indicated R1 required full medication management and setup.<br><br>R1's medication administration record (MAR) indicated that the licensee was managing the | 01710 | | |

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| 01710 | Continued From page 31<br><br>following medications:<br>- amlodipine 5mg tablet;<br>- Cerovite Silver Tab;<br>- D3 1,000 unit capsule;<br>- famotidine 20mg tablet;<br>- gabapentin 300mg capsule;<br>- levothyroxine 150mcg tablet;<br>- lidocaine 5% ointment;<br>- lisinopril 20mg tablet;<br>- milk of magnesia 400mg/5ml suspension;<br>- oyster calcium 500mg tablet;<br>- Risperdal Consta 25mg injection;<br>- Senna-Time S 8.6-50mg tablet;<br>- tadalafil 10mg tablet;<br>- trazodone 50mg tablet, and<br>- venlafaxine 150mg capsule.<br><br>On July 30, 2024, at 9:14 a.m., during an interview with R1, the surveyor observed R1 had a full bottle of Advil 200 milligrams (mg), green tea herbal supplement, and Nyquil cough + DM on their bedside table. R1 stated they took the Advil when their back hurts, they took the green tea supplement daily, and used the Nyquil cough + DM when they felt the need to cough.<br><br>On July 31, 2024, at 2:37 p.m., clinical nurse supervisor (CNS)-E stated R1 was receiving full medication management services, which meant there should be no over the counter medications in the room of R1. CNS-E stated they were unaware of the medications in R1's room and they would complete an assessment as soon as possible to ensure R1 was safely taking medications independently. CNS-E stated staff should have informed the registered nurse of any over the counter medication found in a resident's room that was receiving medication management. | 01710 | | |

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| 01710 | Continued From page 32<br><br>The licensee's 5.13 Storage of Medications policy indicated medications shall be stored consistent with each individual home care client's (resident's) medication management plan and service plan. The licensee's policy included language for Comprehensive Home Care providers found in MN Statutes 144A, not language for Assisted Living providers found in MN Statutes 144G.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01710 | | |
| 01730 SS=F | 144G.71 Subd. 5 Individualized medication management plan<br><br>(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:<br>(1) a statement describing the medication management services that will be provided;<br>(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;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management | 01730 | | |

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| 01730 | Continued From page 33<br><br>tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(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.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R2).<br><br>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).<br><br>The findings include:<br><br>R1 | 01730 | | |

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| 01730 | Continued From page 34<br><br>R1 was admitted to the licensee on July 31, 2023, and began receiving assisted living services.<br><br>R1's diagnoses included illness unspecified (primary), insomnia, essential hypertension, hypothyroidism, constipation acute embolism and thrombosis of deep veins of upper extremities, and major depressive disorder.<br><br>R1's Service Plan -Waiver, dated February 8, 2023, indicated R1 received assistance with ambulation, appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, assistance with managing finances, medication administration, shopping assistance, and transfer assistance.<br><br>R1's medication management plan, dated January 31, 2024, lacked descriptions of the type of medication storage system based on resident's needs, the person responsible for monitoring medication supplies and refills, the medication management tasks that may be delegated to unlicensed personnel (ULP)s, and procedures for staff to notify an RN when problems arose.<br><br>R2<br>R2 was admitted to the licensee on August 4, 2022, and began receiving assisted living services.<br><br>R2's diagnoses included bipolar disorder, dorsalgia (back or spine pain, including low back, mid back, and sciatic pain), major depressive disorder, and emphysema.<br><br>R2's Service Plan -Waiver, dated August 4, 2022, indicated R2 received assistance with appointment reminders, bathing assistance, behavior management, dressing, grooming, | 01730 | | |

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| 01730 | Continued From page 35<br><br>laundry, assistance with managing finances, meal assistance, medication administration, positioning, safety checks, shopping assistance, and assistance with transfers.<br><br>R2's medication management plan, dated January 31, 2024, lacked descriptions of the type of medication storage system based on resident's needs, the person responsible for monitoring medication supplies and refills, the medication management tasks that may be delegated to ULP, and procedures for staff to notify an RN when problems arose.<br><br>On July 31, 2024, at 2:37 p.m., clinical nurse supervisor (CNS)-E stated they were unaware the above listed items were required components for resident medications management plans.<br><br>On August 1, 2024, at 1:17 p.m., licensed assisted living director (LALD)-A sent an email to the surveyor which indicated the licensee did not have a specific policy on medication management plans.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced | 01880 | | |

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| 01880 | Continued From page 36<br><br>by:<br>Based on observation, interview, and record review, the licensee failed store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>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).<br><br>The findings include:<br><br>On August 1, 2024, at 10:26 a.m., the surveyor observed the facility's medication refrigerator located in a breezeway room that connected the garage to the main living area. The medication refrigerator was unlocked and unsecured and contained six unopened boxes of Risperdal Consta 25mg injections (an antipsychotic medication) belonging to R1. Each box contained one 25 mg syringe, one pre-filled syringe containing 2 milliliters (mL) of diluent, one 21 gauge 1" needle, and one 20 gauge 2" needle. The medication refrigerator had no locking mechanism to secure the medication and no thermometer to ensure proper temperature control of medications.<br><br>The manufacturer's instructions printed on the side of the medication packaging indicated the following:<br>- Store in outer carton/container. Store in the | 01880 | | |

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| MINN CARE HOME HEALTH | 7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
|---|---|---|---|---|
| 01880 | Continued From page 37<br><br>refrigerator, 2°C - 8°C (36°F - 46°F). If refrigeration is unavailable, product can be stored at temperatures not exceeding 25°C (77°F) for no more than 7 days prior to administration. Do not expose unrefrigerated product to temperatures above 25°C (77°F). Protect from light.<br><br>On August 1, 2024, at 10:26 a.m., unlicensed personnel (ULP)-C stated that they were instructed to ensure the medication refrigerator was set to the current setting. ULP-C stated there was no thermometer to monitor the temperatures of the refrigerator, or system in place to document temperatures.<br><br>On August 2, 2024, at 9:50 a.m., CNS-E stated the licensee stored all refrigerated medications in the medication refrigerator, and it did not occur to them that the refrigerator should be secured.<br><br>On August 2, 2024, at 9:55 a.m., CNS-E stated the expectation of the facility was to ensure medications were stored according to manufacturer's instructions. CNS-E stated they thought there was a thermometer for monitoring the temperature of the medications.<br><br>The licensee's 5.13 Storage of Medications policy date January 1, 2020, indicated the following:<br>- Medications shall be stored consistent with each individual home care clients' (resident's) medication management plan and service plan.<br>- Medications managed by the home care provider shall be stored to prevent diversion of medications by clients or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications.<br>- Medications managed outside of a client's private "living space" must be in securely locked | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37270 | A. BUILDING: _____ B. WING _____ | 08/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINN CARE HOME HEALTH | 7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
|---|---|---|---|---|
| 01880 | Continued From page 38<br><br>and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup.<br>- Medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen).<br>The licensee's policy included language for Comprehensive Home Care providers found in MN Statutes 144A, not language for Assisted Living providers found in MN Statutes 144G.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information.<br><br>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 | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37270 | A. BUILDING: _____ B. WING _____ | 08/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINN CARE HOME HEALTH | 7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 39<br><br>cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On August 1, 2024, at 10:26 a.m., the surveyor observed the facility's medication refrigerator located in a breezeway room that connected the garage to the main living area. The medication refrigerator contained six unopened boxes of Risperdal Consta 25mg injections (an antipsychotic medication) belonging to R1. Three of the six boxes appeared to have been damaged with prescription labels faded and unreadable.<br><br>On August 1, 2024, at 1:17 p.m., via email, licensed assisted living director (LALD)-A indicated the licensee did not have a specific policy for damaged medication labels.<br><br>On August 2, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-E stated the expectation was to contact the pharmacy to reorder medications if the label of the medication label is unreadable. CNS-E stated "If I can't read the label, I can't use it."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01910 SS=F | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37270 | A. BUILDING: _____ B. WING _____ | 08/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINN CARE HOME HEALTH | 7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
|---|---|---|---|---|
| 01910 | Continued From page 40<br><br>resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for three of three discharged residents (R3, R4, R5).<br><br>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 | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37270 | A. BUILDING: _____ B. WING _____ | 08/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINN CARE HOME HEALTH | 7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
|---|---|---|---|---|
| 01910 | Continued From page 41<br><br>failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R3 was discharged from the licensee on July 12, 2023.<br><br>R3's record contained a medication disposition record that included the medication's name, strength, prescription number as applicable, but did not include quantity, or to whom the medications were given.<br><br>R4 was discharged from the licensee on April 10, 2023.<br><br>R5 was discharged from the licensee on May 17, 2023.<br><br>On August 1, 2024, at 10:39 a.m., the surveyor obtained access to a locked basement storage room. Inside of the room were multiple large garbage bags full of multiple prescription medications belonging to R3, R4, and R5.<br><br>On August 1, 2024, at 12:13 p.m., licensed assisted living director (LALD)-B stated the medications belonging to R3, R4, and R5 were still stored on-site despite the residents having been discharged over a year ago.<br><br>On August 1, 2024, at 12:36 p.m., LALD-B stated that they were aware of the medications stored in the facility belonging to residents that had been discharged, and the licensee was working on reaching out to the correct entities for the proper disposal of medications. The surveyor asked why this process has not been completed in over year since the most recent discharge. LALD-B stated, | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37270 | A. BUILDING: _____ B. WING _____ | 08/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINN CARE HOME HEALTH | 7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
|---|---|---|---|---|
| 01910 | Continued From page 42<br>"we are still working on it".<br><br>On August 2, 2024, at 9:55 a.m., clinical nurse supervisor (CNS)-E stated, "I think I will need to ensure that medications are disposed at time of discharge."<br><br>The licensee's 5.17 Disposal of Medication date January 1, 2020, indicated current unused medications managed by the home care provider will be returned to the pharmacy for credit, or given to the client or the client's representative, when the client's medications are no longer managed by the home care provider, or the medication has been discontinued by the prescriber. The licensee's policy included language for Comprehensive Home Care providers found in MN Statutes 144A, not language for Assisted Living providers found in MN Statutes 144G.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *07/29/24*
Time: 12:10:46
Report: 7994241140

# Food and Beverage Establishment Inspection Report



**Location:**

Minn Care Home Health
7215 Fremont Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

**Establishment Info:**

ID #: 0037453
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7632006270
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(1)*** ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS STORED ON THE TOP SHELF OF FRIDGE. MOVE THESE AS LOW AS POSSIBLE IN THE FRIDGE.

*Comply By: 07/29/24*

**3-500B Microbial Control: hot and cold holding**

***3-501.16A2*** ***** Priority 1 *****

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

FRIDGE FOUND HOLDING SOME FOODS ABOVE 41 F. FACILITY ADJUSTED AND WILL MONITOR.

*Comply By: 07/29/24*

**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.

DATE MARKS MISSING ON VARIOUS RTE FOODS.

*Comply By: 07/29/24*

**5-200C Plumbing: Maintenance, fixture location**

***5-205.11AB*** ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

THERE IS ONLY A SINGLE COMPARTMENT SINK IN THE KITCHEN. ENSURE THIS IS ONLY USED FOR HAND WASHING OR REPLACED WITH A 2 COMPARTMENT SINK.

*Comply By: 07/29/24*

**6-300 Physical Facility Numbers and Capacities**

***6-301.11*** ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

HAND SOAP WAS IN A BOTTLE WITHOUT A PUMP. SPOKE WITH OPERATOR ABOUT VARIOUS APPROVED SOAP DISPENSERS.

*Comply By: 07/29/24*

**6-300 Physical Facility Numbers and Capacities**

***6-301.12*** ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

PAPER TOWELS WERE FOUND LOOSE. PROVIDE A PAPER TOWEL ROLL HOLDER FOR KITCHEN AREA.

*Comply By: 07/29/24*

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 2 | 4 | 0 |

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, GRANITE COUNTER TOPS AND POPCORN TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

Type: Full
Date: *07/29/24*
Time: 12:10:46
Report: 7994241140
Minn Care Home Health

# 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 7994241140 of 07/29/24.

Certified Food Protection Manager: Dmitre Kustrich

Certification Number: 120894 Expires: 10/03/26

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
Dmitre Kustrich

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241140

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

**Minnesota Department of Health**

**625 Robert Street North**
**St Paul**

| | |
|---|---|
| No. of RF/PHI Categories Out | 4 |
| No. of Repeat RF/PHI Categories Out | 0 |
| Legal Authority MN Rules Chapter 4626 | |

**Date** 07/29/24
**Time In** 12:10:46
**Time Out**

| Minn Care Home Health | **Address** 7215 Fremont Avenue North | **City/State** Brooklyn Center, MN | **Zip Code** 55430 | **Telephone** 7632006270 |
|---|---|---|---|---|
| **License/Permit #** 0037453 | **Permit Holder** | **Purpose of Inspection** Full | **Est Type** | **Risk Category** |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| **Supervision** | | | | |
| 1 | IN OUT | PIC knowledgeable; duties & oversight | | |
| 2 | IN OUT N/A | Certified food protection manager, duties | | |
| **Employee Health** | | | | |
| 3 | IN OUT | Mgmt/Staff;knowledge,responsibilities&reporting | | |
| 4 | IN OUT | Proper use of reporting, restriction & exclusion | | |
| 5 | IN OUT | Procedures for responding to vomiting & diarrheal events | | |
| **Good Hygenic Practices** | | | | |
| 6 | IN OUT N/O | Proper eating, tasting, drinking, or tobacco use | | |
| 7 | IN OUT N/O | No discharge from eyes, nose, & mouth | | |
| **Preventing Contamination by Hands** | | | | |
| 8 | IN OUT N/O | Hands clean & properly washed | | |
| 9 | IN OUT N/A N/O | No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed | | |
| 10 | IN OUT | Adequate handwashing sinks supplied/accessible | | |
| **Approved Source** | | | | |
| 11 | IN OUT | Food obtained from approved source | | |
| 12 | IN OUT N/A N/O | Food received at proper temperature | | |
| 13 | IN OUT | Food in good condition, safe, & unadulterated | | |
| 14 | IN OUT N/A N/O | Required records available; shellstock tags, parasite destruction | | |
| **Protection from Contamination** | | | | |
| 15 | IN OUT N/A N/O | Food separated and protected | | |
| 16 | IN OUT N/A | Food contact surfaces: cleaned & sanitized | | |
| 17 | IN OUT | Proper disposition of returned, previously served, reconditioned, & unsafe food | | |

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| **Time/Temperature Control for Safety** | | | | |
| 18 | IN OUT N/A N/O | Proper cooking time & temperature | | |
| 19 | IN OUT N/A N/O | Proper reheating procedures for hot holding | | |
| 20 | IN OUT N/A N/O | Proper cooling time & temperature | | |
| 21 | IN OUT N/A N/O | Proper hot holding temperatures | | |
| 22 | IN OUT N/A | Proper cold holding temperatures | | |
| 23 | IN OUT N/A N/O | Proper date marking & disposition | | |
| 24 | IN OUT N/A N/O | Time as a public health control: procedures & records | | |
| **Consumer Advisory** | | | | |
| 25 | IN OUT N/A | Consumer advisory provided for raw/undercooked food | | |
| **Highly Susceptible Populations** | | | | |
| 26 | IN OUT N/A | Pasteurized foods used; prohibited foods not offered | | |
| **Food and Color Additives and Toxic Substances** | | | | |
| 27 | IN OUT N/A | Food additives: approved & properly used | | |
| 28 | IN OUT | Toxic substances properly identified, stored, & used | | |
| **Conformance with Approved Procedures** | | | | |
| 29 | IN OUT N/A | Compliance with variance/specialized process/HACCP | | |

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

## GOOD RETAIL PRACTICES

**Good Retail Practices** are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

| | | | COS | R |
|---|---|---|---|---|
| **Safe Food and Water** | | | | |
| 30 | IN OUT N/A | Pasteurized eggs used where required | | |
| 31 | | Water & ice obtained from an approved source | | |
| 32 | IN OUT N/A | Variance obtained for specialized processing methods | | |
| **Food Temperature Control** | | | | |
| 33 | | Proper cooling methods used; adequate equipment for temperature control | | |
| 34 | IN OUT N/A N/O | Plant food properly cooked for hot holding | | |
| 35 | IN OUT N/A N/O | Approved thawing methods used | | |
| 36 | | Thermometers provided & accurate | | |
| **Food Identification** | | | | |
| 37 | | Food properly labled; original container | | |
| **Prevention of Food Contamination** | | | | |
| 38 | | Insects, rodents, & animals not present | | |
| 39 | | Contamination prevented during food prep, storage & display | | |
| 40 | | Personal cleanliness | | |
| 41 | | Wiping cloths: properly used & stored | | |
| 42 | | Washing fruits & vegetables | | |

| | | | COS | R |
|---|---|---|---|---|
| **Proper Use of Utensils** | | | | |
| 43 | | In-use utensils: properly stored | | |
| 44 | | Utensils, equipment & linens: properly stored, dried, & handled | | |
| 45 | | Single-use/single service articles: properly stored & used | | |
| 46 | | Gloves used properly | | |
| **Utensil Equipment and Vending** | | | | |
| 47 | | Food & non-food contact surfaces cleanable, properly designed, constructed, & used | | |
| 48 | | Warewashing facilities: installed, maintained, & used; test strips | | |
| 49 | | Non-food contact surfaces clean | | |
| **Physical Facilities** | | | | |
| 50 | | Hot & cold water available; adequate pressure | | |
| 51 | | Plumbing installed; proper backflow devices | | |
| 52 | | Sewage & waste water properly disposed | | |
| 53 | | Toilet facilities: properly constructed, supplied, & cleaned | | |
| 54 | | Garbage & refuse properly disposed; facilities maintained | | |
| 55 | | Physical facilities installed, maintained, & clean | | |
| 56 | | Adequate ventilation & lighting; designated areas used | | |
| 57 | | Compliance with MCIAA | | |
| 58 | | Compliance with licensing & plan review | | |

**Food Recalls:**

**Person in Charge (Signature)** **Date:** 07/29/24

Inspector (Signature) Crystal Elva