DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 8, 2022

Administrator
Comfort Residence Blaine
10669 Ulysses Street Northeast
Blaine, MN 55449

RE: Project Number(s) SL30479015

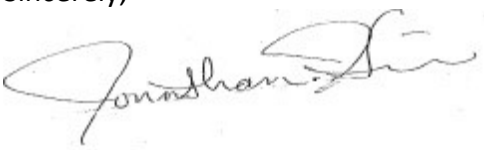
Dear Administrator:

On October 12, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 14, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



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

PMB

Electronically Delivered

October 12, 2022

Administrator
Comfort Residence Blaine
10669 Ulysses Street Northeast
Blaine, MN 55449

RE: Project Number(s) SL30479015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents no violations. The Department of Health documents the state licensing correction orders using federal software. Please disregard the heading of the fourth column that states, "Provider's Plan of Correction." A plan of correction is not required.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30479	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT RESIDENCE BLAINE	10669 ULYSSES STREET NE BLAINE, MN 55449

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30479015 On September 12 through September 14, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 25 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated September 12, 2022, for the specific	0 480		

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0 480	Continued From page 2 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure tuberculosis (TB) history and symptom screening was performed for one of two employees (unlicensed personnel (ULP)-E) upon hire. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number	0 660		

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0 660	Continued From page 3 of staff are involved, or the situation has occurred only occasionally). The findings include: The Facility TB Risk Assessment dated May 10, 2022, identified the facility was at a low risk for transmission. ULP-E was hired on July 15, 2019, and provided direct cares for the residence of the facility. ULP-E's record lacked documentation of a TB history and symptom screening. On September 13, 2022, at 1:27 p.m., registered nurse (RN)-A stated ULP-E had an X-ray and TB gold test done but was unable to locate documentation of TB history and symptom screening. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's TB Prevention Control policy dated July 23, 2021, indicated screening to include: 1. Assessing for current symptoms of Active TB 2. Assessing for TB risk factors and TB history	0 660		

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0 660	Continued From page 4 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780		

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0 780	Continued From page 5 Based on observation and interview, the licensee failed to provide interconnection of smoke alarms in the resident apartment units #5, #6, and #14. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 13, 2022, approximately from 9:45 a.m. to 11:30 p.m., survey staff toured the facility with the maintenance staff (MS)-I. During the tour, survey staff observed the MS-I tested the smoke alarms inside the two-bedroom resident apartment units #6 and #14, and the one-bedroom apartment unit #5, the smoke alarms sounded local and were not interconnected as required. Survey staff explained to the MS-I that the smoke alarms inside each bedroom and outside the vicinity of the bedrooms of each apartment must be interconnected such that when one alarm is activated, all smoke alarms inside the apartment unit must sound throughout the apartment unit. The MS-I verified the findings. On September 13, 2022, at approximately 12:15 p.m., during the exit interview, the licensed assisted living director (LALD)-B, MS-I, and assisted living director (ALD)-C acknowledged the above findings.	0 780		

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0 780	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings are: On September 13, 2022, approximately from 9:45 a.m. to 11:30 p.m., survey staff toured the facility	0 800		

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0 800	Continued From page 7 with the maintenance staff (MS)-I. During the tour, survey staff observed the following: 1) The assisted living apartment units of the facility lacked carbon monoxide detection protection at required locations of sleeping rooms for compliance with carbon monoxide detection buildings with forced air fuel-burning equipment/appliance in accordance with state law. The MS-I confirmed the finding after further investigation in the mechanical rooms for centralized protection. 2) A fire sprinkler head near resident apartment unit #5 was loose and missing an escutcheon plate for the proper functioning of the fixture. 3) Multiple extension cords were in use in resident apartment unit #18 that posed a potential electrical fire hazard from overloading the electrical circuits. 4) In resident apartment unit #19, the ceiling had water stains around the light fixtures from water damage that need to be investigated and resolved. 5) In resident unit #5, a light cover was missing. 6) In resident units #6 and FF, the exhaust fan in the bathroom was layered with thick, dark dust. 7) In unoccupied resident unit # MM, the return vent opening (without cover) was observed with a thick black layer of dust inside the duct opening. Survey staff asked the MS-I about the last cleaning of the venting system and the MS-I was unclear about their schedule. 8) In the laundry room across from resident unit	0 800		

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0 800	Continued From page 8 #CC: -The fire-rated door for the laundry room did not close and latch when the MS-I closed the door to protect the corridor. -The thread hose hosebibb in the laundry room did not have a backflow preventer (vacuum breaker) to protect the building water supply system from potential cross-connection. -The back wall of the dryers in the laundry room had significant collection of lint. 9) The portable fire extinguisher cabinets failed to be readily accessible as MS-I did not have a key to access the cabinets and used a flat screwdriver to open the cabinets. Survey staff asked if employees hsd keys to access and the MS-I did not know. 10) Ansul system in the kitchen lacked the required inspections and testing. The tag showed a record of service date of "9/2021". The inspection and testing must be performed every 6 months. 11) A portion of the memory care courtyard fence was damaged and in need of repair. The MS-I stated that he did not know how the damage occurred. On September 13, 2022, at approximately 12:15 p.m., during the exit interview, the licensed assisted living director (LALD)-B, the MS-I, and the assisted living director (ALD)-C acknowledged the above findings. ALD-C commented that they would provide a maglock for the gate in the memory care court yard and repair the fence to provide a secured area for the memory care residents. No further information was provided.	0 800		

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0 800	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 10 This MN Requirement is not met as evidenced by: Based on documentation review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the minimum number of evacuation drills, and the required employee and resident training on fire safety training. This has the potential to directly affect the safety of residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 13, 2022, at approximately 11:30 a.m., survey staff reviewed the facility's fire safety and evacuation plan and related documentation. The review of the documentation indicated the following: FIRE SAFETY AND EVACUATION PLAN 1) Document review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation during a fire or similar emergency. . Unique or unusual situations that must be considered are residents who have mobility limitations, cognitive impairment, deaf or blind, or any residents needing assistance during an evacuation that must be addressed in the fire safety and evacuation plan.	0 810		

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0 810	Continued From page 11 2)The floor plans lacked location and numbers of sleeping (apartment) rooms and accurate locations of sleeping rooms. Resident sleeping rooms #18 and #19 were not shown on the floor plan. 3) The plan lacked fire protection procedures necessary for the residents. TRAINING 1) Documentation review indicated the licensee failed to provide employee training on the fire safety and evacuation plan upon hire and twice per year thereafter. 2) Document review indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation. EVACUATION DRILLS Document review indicated the licensee failed to provide fire and evacuation drills to show compliance with the minimum number of required employee fire and evacuation drills of two drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. No drill records were available for review. On September 13, 2022, at approximately 12:15 p.m., during the exit interview, the licensed assisted living director (LALD)-A, MS-I, and assisted living director (ALD)-C acknowledged the above findings. ALD-C stated that they would be working with the local fire department to get some training. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen	0 810		

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	30479	A. BUILDING: _____ B. WING _____	09/14/2022

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0 810	Continued From page 12 (14) days	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R3). 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	0 930		

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0 930	Continued From page 13 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted September 19, 2014, and received services including assistance with housekeeping, activities, laundry, blood glucose management, meals, grooming, bathing, dressing, and medication management. R2 was admitted June 1, 2018, and received services including assistance with housekeeping, activities, laundry, eating, bathing, mobility, and medication management. R3 was admitted August 17, 2022, and received services including assistance with housekeeping, meals, activities, and medication management. R1, R2, and R3's assisted living contract, dated July 23, 2021, July 16, 2021, and August 18, 2022, respectively, lacked clear and conspicuous notice of the right under section 144G.54 to appeal the termination of an assisted living contract. On September 13, 2022, at 9:14 a.m., assisted living director (ALD)-C stated all residents received the same assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 950 SS=C	144.50 Subd. 3 Designation of representative	0 950		

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0 950	Continued From page 14 (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative, on a separate form, including statutory language, for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a	0 950		

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0 950	Continued From page 15 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: R1 was admitted September 19, 2014, and received services including assistance with housekeeping, activities, laundry, blood glucose management, meals, grooming, bathing, dressing, and medication management. R2 was admitted June 1, 2018, and received services including assistance with housekeeping, activities, laundry, eating, bathing, mobility, and medication management. R3 was admitted August 17, 2022, and received services including assistance with housekeeping, meals, activities, and medication management. R1, R2, and R3's assisted living contract, dated July 23, 2021, July 16, 2021, and August 18, 2022, respectively, lacked documentation indicating the residents were given the opportunity to designate a representative for certain purposes, on a separate form, with required statutory language. On September 13, 2022, at 3:14 p.m., assisted living director (ALD)-C stated the form used in the contract to designate a representative was not their updated version. ALD-C verified all existing residents had received the same contract. No further information was provided.	0 950		

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0 950	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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 licensee failed to ensure direct-care staff completed the required two (2) hours of annual dementia care training for one of two employees (unlicensed personnel (ULP)-E). 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 an isolated scope (when one or a limited number of	01540		

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01540	Continued From page 17	01540		

residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

The licensee was a licensed assisted living facility with dementia care (ALFDC).

ULP-E was hired on July 15, 2019 and provided direct care services for residents of the facility.

ULP-E's electronic training log indicated eight (8) hours of required dementia training were completed on July 22-23, and August 1, 2019. The training log indicated subsequent annual training was completed on August 5, 2020, which was greater than one year after the previous training, and only met one (1) of the required two (2) hours of annual dementia care training.

ULP-E's record included documentation titled "Annual Inservice 2021" dated December 20, 2021 (greater than one year after the previous dementia care training). The document did not indicate the number of dementia care training hours completed.

On September 13, 2022, at 1:39 p.m., office manager (OM)-H provided ULP-E's training log and stated it was all of the training they had to provide.

On September 13, 2022, at 1:43 p.m., assisted living director (ALD)-C acknowledged the documents did not meet the annual training and verified ULP-E had no additional dementia training documented.

The licensee's Assisted Living with Memory Care

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01540	Continued From page 18 Dementia Training policy dated July 29, 2021, indicated, "direct-care employees will have a minimum of two hours of training on topics related to dementia for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned	01650		

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01650	Continued From page 19 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted September 19, 2014, and received services including assistance with housekeeping, activities, laundry, blood glucose management, meals, grooming, bathing, dressing, and medication management. R2 was admitted June 1, 2018, and received services including assistance with housekeeping, activities, laundry, eating, bathing, mobility, and medication management. R3 was admitted August 17, 2022, and received services including assistance with housekeeping, meals, activities, and medication management. On September 13, 2022, at 9:14 a.m., assisted living director (ALD)-C stated all residents received the same assisted living contract.	01650		

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01650	Continued From page 20 On September 13, 2022, at 1:31 p.m., ALD-C verified the contract is the only agreement signed by the resident or their representative. ALD-C acknowledged the contract would be considered their service plan. R1, R2, and R3's assisted living contract (identified as the service plan by ALD-C), dated July 23, 2021, July 16, 2021, and August 18, 2022, respectively, lacked the following: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; and (4) the schedule and methods of monitoring staff providing services. On September 13, 2022, at 2:35 p.m., registered nurse (RN)-A stated he understood the need to have services listed on a service plan, and, if used as a service plan, their contract was missing an individualized list of services provided and frequency of those services, the category of staff providing the services, and also the method of staff supervision. The licensee's Contents of Service Plans policy reviewed July 28, 2021, indicated, service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services	01650		

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01650	Continued From page 21 f. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency iv. Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition v. Identification of and information on who has authority to sign for the resident in an emergency vi. Circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

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01760	Continued From page 22 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered per providers orders for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION ERROR R1 received services including assistance with blood glucose management, and medication management. R1's record included a prescriber order dated June 13, 2022, indicating, "Humalog 15 u [units] SQ [subcutaneously (injected under the skin) TID [three times daily] with meals for DM [diabetes mellitus]". On September 12, 2022, at 4:28 p.m., during a medication administration observation, unlicensed personnel (ULP)-E was observed to administer medications to R1 including Humalog (a fast-acting insulin). Prior to administering R1's scheduled insulin dose, ULP-E failed to prime the insulin pen by injecting 2 units into the waste receptacle.	01760		

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01760	Continued From page 23 On September 12, 2022, at 4:38 p.m., ULP-E verified she did not prime the insulin pen. ULP-E stated she did not recall being trained to prime the insulin pen prior to insulin administration. On September 12, 2022, at 4:47 p.m., registered nurse (RN)-A stated staff was trained on medication administration including insulin administration by the RN. RN-A further stated staff were instructed to prime the insulin pen before administering the prescribed dose. Manufacturer instructions, revised March 30, 2020, indicated the Humalog insulin pen be primed before each injection by turning the dose knob to two (2) units, holding the pen vertical with the needle pointing up, and pushing the dose knob until it stops. The instructions further indicated if drops of medication were not visible at the tip of the needle, the needle should be changed and the process repeated. DOCUMENTATION R2 was admitted June 1, 2018, and received services including assistance with medication management. R2's record included medication orders signed August 31, 2022, including "Ativan [lorazepam] 0.5 mg [milligrams] soluble 0.5 mg tablet, disintegrating; Administer 1 tab(s) sublingually 4 times a day for anxiety". R2's medication administration record (MAR) for September 1-13, 2022, indicated, "LORazepam Tablet 0.5 [milligrams (mg)] Give 1 tablet by mouth every 6 hours for anxiety". The MAR indicated R2 was administered lorazepam 0.5 mg, at 12:00 p.m. and 6:00 p.m. daily from	01760		

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01760	Continued From page 24 September 1-13, and additionally at 12:00 a.m. and 6:00 a.m. on September 4 and at 12:00 a.m. on September 9, 2022. The MAR lacked documentation of lorazepam 0.5 mg not being administered for 23 out of 52 scheduled doses. The MAR did not indicate R2 refused the medication. On September 14, 2022, at 12:37 p.m., RN-A acknowledged the scheduled lorazepam for R2 should be documented why it was not administered and documented as refused if R2 refused the medication. The licensee's administration of oral medications policy, reviewed August 23, 2021, indicated, "Using the procedure for documentation on the MAR/EMAR, staff will document that the medications were taken, refused, or held and will document and report to the Nurse as directed by the Nurse if medications are not administered as prescribed." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the	02040		

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assessment must be assessed and mitigated to protect the residents from harm; and
(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.

This MN Requirement is not met as evidenced by:
Based on observation, documentation review, and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services.

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

The findings include:

On September 13, 2022, approximately from 9:45 a.m. to 11:30 p.m., survey staff toured the facility with the maintenance staff (MS)-I.

On September 13, 2022, at approximately 12:00 p.m., survey staff reviewed the facility hazard vulnerability dated August 1, 2021, with a title of "Talamore, St. Cloud". The review of the plan documentation indicated the following findings:

1) The plan documentation lacked a site-specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30479	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT RESIDENCE BLAINE	10669 ULYSSES STREET NE BLAINE, MN 55449

(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
02040	Continued From page 26 safety risk assessment on and around the property to identify vulnerabilities to protect the memory care residents from harm. This finding was evident as the documentation provided did not include site-specific vulnerability content or safety risk assessment on and around the property. 2) The plan documentation lacked site-specific mitigations to protect residents from harm. Specific prevention measures to mitigate risks from the identified potential hazard and vulnerability assessment must be developed and documented in the plan for all potential hazards associated with this property. On September 13, 2022, at approximately 12:15 p.m., during the exit interview, the licensed assisted living director (LALD)-B, the MS-I, and the assisted living director (ALD)-C acknowledged the above findings. Survey staff explained the safety risk assessment and mitigation plan must be site-specific and directed to protecting the memory care residents from harm such as an assessment of risk and mitigation regarding an unsecured courtyard. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=F	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30479	A. BUILDING: _____ B. WING _____	09/14/2022

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02310	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supplemental oxygen (O2) tanks were stored safely to prevent tipping. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 had diagnoses including dementia. R1 received services including assistance with oxygen administration, and medication management. R1's therapy and treatment plan dated December 2, 2021, indicated R1 required daily O2 with a flow rate of 2-4 liters (L) via nasal cannula (tubing delivering O2 via nostrils). On September 12, 2022, at 11:50 a.m., licensed practical nurse (LPN)-D provided a tour of the facility. R1's room was observed to have multiple oxygen tanks standing upright and unsecured on the floor. LPN-D indicated it was normal practice to store R1's O2 tanks in her room. LPN-D further stated the medical supply company delivered the O2 tanks to R1's room and removed the empty tanks.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30479	A. BUILDING: _____ B. WING _____	09/14/2022

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02310	Continued From page 28 On September 12, 2022, at 12:55 p.m., R1's room was observed to have 17 O2 tanks labeled M9 with stickers indicating they each contained 248 liters (L) of O2. Eight (8) tanks of O2 were observed to be standing upright in cardboard boxes. Nine (9) tanks of O2 were observed standing upright not in cardboard boxes, and not otherwise secured to prevent tipping. On September 12, 2022, at 1:57 p.m., during a telephone interview, a representative (R)-J of the O2 supply company stated the oxygen tanks could be stored upright or lying down, but needed to be secured to prevent tipping or rolling. The representative further stated the tanks were delivered in cardboard boxes that prevented the tanks from tipping over. On September 12, 2022, at 4:47 p.m., registered nurse (RN)-A verified the O2 tanks should have been stored upright and prevented from falling over. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements (based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code), dated April 16, 2020, indicated the types of hazards associated with oxygen as: 1) General fires and explosions enhanced by oxygen-rich atmospheres 2) Mechanical problems such as physical damage to compressed gas cylinders. The guidance further indicated, "when storing up to 300 cubic feet (ft^3) of oxygen, cylinders must be secured (chains or racks) to prevent them from falling over". The licensee's Administration of Oxygen By Nasal Cannula policy and procedure dated June 24,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30479	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT RESIDENCE BLAINE	10669 ULYSSES STREET NE BLAINE, MN 55449

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02310	Continued From page 29 2021, indicated, "oxygen tanks are to be stored upright." The policy lacked direction to secure oxygen tanks from tipping or rolling. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Follow-Up
Date: *10/13/22*
Time: 10:30:20
Report: 1029221321

Food and Beverage Establishment Inspection Report

Location:
Comfort Residence Blaine
10669 Ulysses Street Ne
Blaine, MN55449
Anoka County, 02

Establishment Info:
ID #: 0038381
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633771800
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 previously issued on 09/12/22 have NOT been corrected.

3-500C Microbial Control: date marking
3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.

DATE MARKINGS MISSING FROM OPENED PACKAGE OF DELI MEAT IN WALK-IN COOLER. CORRECTED DURING INSPECTION.

10/13/22: REPEAT VIOLATION.

Issued on: 09/12/22 *Comply By: 09/12/22*

2-100 Supervision
2-102.12AMN

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

NO EVIDENCE OF CFPM EMPLOYED BY ESTABLISHMENT. EMPLOY CFPM.

10/13/22: REPEAT VIOLATION.

Issued on: 09/12/22 *Comply By: 09/30/22*

Type: Follow-Up
Date: *10/13/22*
Time: 10:30:20
Report: 1029221321
Comfort Residence Blaine

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

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

Follow-up inspection conducted in conjunction with an HRD survey at Comfort Residence Blaine, located at 10669 Ulysses Street Northeast, Blaine, MN 55449.

Follow-up inspection was conducted to assess establishment's progress in addressing previously identified issues, and was conducted in the presence of Tanesha Brewer, Cook; Lesa Fasching, Director; and other staff. All critical violations were corrected and only 2 violations remained uncorrected: 3-501.71A (lack of date marking) and 2-102.12AMN (no CFPM). The cook that was present during the initial inspection, Carla Zaczkowski, had recently quit and Tanesha was now the main cook. Tanesha stated that she had passed the food safety class and was working on obtaining her CFPM. Following the inspection, I emailed Tanesha CFPM attainment information along with food safety fact sheets. An additional follow-up inspection is not warranted, given the establishments corrective actions.

Follow-up inspection emailed to lead HRD surveyor, Renee L. Anderson, BSN, RN-BC, HFE-Nurse Evaluator II, following the inspection.

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 1029221321 of 10/13/22.

Certified Food Protection Manager: Vacant

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Tanesha Brewer
Cook

Signed: _____
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us