



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 16, 2024

Licensee

Twin Cities Group Homes LLC
711 22nd Avenue Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL36339015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 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:

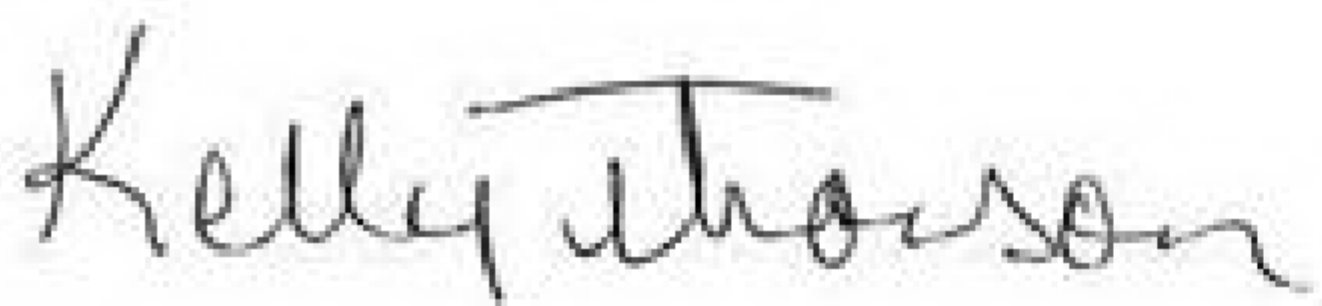
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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,



Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER TWIN CITIES GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 711 22ND AVENUE NE MINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36339015 On September 9, 2024, through September 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; all receiving services under the Assisted Living 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.		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	0 630			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 630	Continued From page 1 individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) included specific measures to be taken to minimize the risk of abuse for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's IAPP dated June 28, 2024, did not include specific measures to be taken to minimize the risk of abuse. On September 10, 2024, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated when she completed reassessments for R3, the interventions did not	0 630			

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0 630	Continued From page 2 show up on the plan, but will add them in right away. The licensee's Vulnerable Adult policy dated October 28, 2023, indicated the vulnerable adult status assessment shall be documented in the clinical record. The plan shall contain specific measures to be taken to minimize the risk of abuse to that person or other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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	0 780			

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0 780	Continued From page 3 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 10, 2024, from 10:00 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor asked LALD/CNS-A to initiate a test of the smoke alarms throughout the home. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: - Bedroom 3 smoke alarm was not installed. - The smoke alarms in multiple locations were installed more than 12 inches from the ceiling. - The smoke alarm in the upstairs hallway was not interconnected with the bedrooms.	0 780			

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0 780	Continued From page 4 On September 10, 2024, at 12:30 p.m., LALD/CNS-A stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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, 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 800			

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0 800	Continued From page 5 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 10, 2024, from 10:00 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The following was observed. GENERAL MAINTENANCE: The basement bathroom had a large hole in the wall and ceiling. The basement living room had two locations where tiles were missing and were a potential tripping hazard. On September 10, 2024, at 12:30 p.m., LALD/CNS-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810			

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0 810	Continued From page 6 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, 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. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810			

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0 810	Continued From page 7 or has potential to affect a large portion or all of the residents). The findings include: On September 10, 2024, licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated October 28, 2023, and "Evacuation and Relocation Plan", undated, failed to include the following: The FSEP 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 provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. The policy indicated a shelter-in-place strategy where residents should wait for instructions from the incident commander. The policy lacked appropriate procedures for residents 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. On September 10, 2024, at 12:30 p.m., LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.	0 810			

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0 810	Continued From page 8 TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On September 10, 2024, at 12:30 p.m., LALD/CNS-A stated they understood the requirements for training residents and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Emergency Preparedness 1.18 Fire Drill Log", undated, indicated evacuation drills were conducted on November 1, 2023, January 1, 2024, March 1, 2024, May 1, 2024, July 1, 2024, and September 1, 2024. No other documentation was provided. On September 10, 2024, at 12:30 p.m., LALD/CNS-A stated there were no additional documented drills for the facility. LALD/CNS-A stated they started working at the facility at the end of September 2023 and did not know if any evacuation drills were completed prior to their start date. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			

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02290	Continued From page 9	02290			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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 9, 2024, at 2:00 p.m., the surveyor observed a sign posted on the wall in the common area indicating no drugs or alcohol allowed at the facility. The facility strictly prohibits the use of drugs and alcohol on the premises. If you need to consume alcohol or use drugs, kindly do so outside the facility. Failure to comply with this policy will result in termination of services. On September 9, 2024, at 2:05 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they restrict alcohol because of the problems it causes with some of	02290			

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02290	Continued From page 10 the residents, it is for their safety but will take the sign down right away. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			



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

Type: Full
Date: 09/10/24
Time: 10:00:00
Report: 1005241227

Food and Beverage Establishment Inspection Report

Page 1

Location:

Twin Cities Group Homes Llc
711 22nd Avenue Ne
Minneapolis, MN55418
Hennepin County, 27

Establishment Info:

ID #: 0039053
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127020331
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 193 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/TURKEY
Temperature: 41 Degrees Fahrenheit - Location: "SAMSUNG" REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: "SAMSUNG" REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/LETTUCE
Temperature: 41 Degrees Fahrenheit - Location: "SAMSUNG" REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH FOOD MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR WENDY ROBARGE.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

Type: Full
Date: 09/10/24
Time: 10:00:00
Report: 1005241227
Twin Cities Group Homes Llc

Food and Beverage Establishment Inspection Report

Page 2

A MAXIMUM REGISTERING THERMOMETER WAS ON SITE AND AFTER INSPECTION OPERATOR SENT INSPECTOR A PICTURE OF THE THERMOMETER THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OVER 160 DEGREES F.

FLOORING IS PAINTED WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE TILE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241227 of 09/10/24.

Certified Food Protection Manager FARDOZA YUSUF

Certification Number: FM112992 Expires: 09/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
FARDOZA YUSUF

Signed:  _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us