Electronically Delivered

December 18, 2024

Licensee
Suburban Residential Care LLC
7019 Morgan Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL36426015

Dear Licensee:

On November 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 30, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 8, 2024

Licensee
Suburban Residential Care LLC
7019 Morgan Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL36426015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 30, 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.

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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36426	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBURBAN RESIDENTIAL CARE LLC	7019 MORGAN 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
0 000	Initial Comments 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: SL36426015-0 On August 26, 2024, through August 30, 2024, the Minnesota Department of Health conducted a full survey at the above provider and the following orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living license. An immediate correction order was identified on August 29, 2024, issued for SL36426015-0, tag identification 0820.	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. 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 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on August 26, 2024, at approximately 10:15 a.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A stated they were not listed as director of record for licensee and stated they would get that corrected. On August 26, 2024, at 11:30 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD/CNS-A currently held an assisted living director license effective through October 31, 2024; the website did not indicate LALD/CNS-A was the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 26, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan lacked evidence of the following requirements: -participate in an annual full-scale exercise that was community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan -conduct an additional annual exercise that may include: a second full-scale exercise that was community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise On August 27, 2024, at 10:30 a.m., during a tour of the facility with licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A, the facility was observed to lack posting of signage and/or information regarding the licensee's emergency disaster or preparedness plan. LALD/CNS-A stated that the EP plan was being under review and that is why it was not posted. LALD/CNS-A further stated that the licensee did not have any records of drills on the EP plan. The licensee's Emergency Preparedness policy dated February 1, 2022, indicated the licensee,	0 680		

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0 680	Continued From page 5 "conduct, at minimum, two emergency preparedness drills every 12 months." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 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 6 Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code provisions. 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 or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on August 29, 2024, from 11:45 a.m. to 12:30 p.m., with licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A, and unlicensed personnel (ULP)-D, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: The exterior window well cover was blocking the emergency escape and rescue window from opening fully in resident room 1 in the basement. Emergency escape and rescue openings are required to be openable for immediate escape in the event of a fire or similar emergency without the use of keys, tools or special knowledge in accordance with current Minnesota Fire Code. The clothes dryer exhaust vent was disconnected in the basement allowing exhaust to be discharged to the space within the building and there was a buildup of lint on the wall behind the dryer. Dryer vent exhaust is required to discharge to the exterior of the building in accordance with current Minnesota Fire Code.	0 780		

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0 780	Continued From page 7 There were used cigarette butts deposited on the ground around the outside cigarette dispensers in the front and back of the facility and inside the garage. Used cigarette butts are required to be deposited in non-combustible dispensers or dispensers manufactured for the purpose of dispensing used cigarette butts in accordance with current Minnesota Fire Code. On August 29, 2024, at 12:30 p.m., LALD/CNS-A, and ULP-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
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	0 810		

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0 810	Continued From page 8 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 required content, make the plan readily available, provide 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 or has potential to affect a large portion or all of the residents). The findings include: On August 29, 2024, at 12:30 p.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A, and unlicensed personnel (ULP)-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810		

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0 810	Continued From page 9 evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee-provided FSEP, lacked the following: The resident sleeping room numbers were not included on the evacuation plan map. The available FSEP did not identify specific fire protection actions for residents as evident by not providing specific written procedures for residents in the event of a fire or similar emergency in the FSEP. The available FSEP 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 failed to include in writing and available resident evacuation status/ unique needs for evacuation in the event of a fire or similar emergency. During an interview on August 29, 2024, at 12:55 p.m., LALD/CNS-A, and ULP-D, stated documentation for resident actions and resident individual evacuation status/unique needs was not available. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation the required employee training	0 810		

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0 810	Continued From page 10 was completed. Record review of the available documentation indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the required training was provided to residents. During an interview on August 29, 2024, at 12:55 p.m., LALD/CNS-A, and ULP-D, stated documentation was not available for FSEP training for employees or residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly	0 820		

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0 820	Continued From page 11 affect all or a large portion of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 a facility tour on August 29, 2024, from 11:45 a.m. to 12:30 p.m., with licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A, and unlicensed personnel (ULP)-D, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 2, 3, and 4. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 2, emergency escape and rescue clear window opening measurements were 31.5 inches wide, 15 inches in height, and 473 square inches in openable area. The window was measured with LALD/CNS-A, ULP-D, and the surveyor present. The window did not meet the minimum requirements for clear opening height and total square inch area. Resident sleeping room 3, emergency escape and rescue clear window opening measurements were 31.5 inches wide, 15 inches in height, and 473 square inches in openable area. The window was measured with LALD/CNS-A, ULP-D, and	0 820		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 12 the surveyor present. The window did not meet the minimum requirements for clear opening height and total square inch area. Resident sleeping room 4, emergency escape and rescue clear window opening measurements were 35 inches wide, 16.25 inches in height, and 569 square inches in openable area. The window was measured with LALD/CNS-A, ULP-D, and the surveyor present. The window did not meet the minimum requirements for clear opening height and total square inch area. The surveyor explained to LALD/CNS-A, and ULP-D, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. If the window clear opening measures the minimum of 20 inches in one direction, the other measurement will be more than 20 inches in order to achieve the total square inch area of 648 square inches. These deficient conditions were visually verified by LALD/CNS-A, and ULP-D, accompanying on the tour. The surveyor explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate	0 820		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36426	A. BUILDING: _____ B. WING _____	08/30/2024

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01440	Continued From page 13 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) supervised unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for one of one employee (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36426	A. BUILDING: _____ B. WING _____	08/30/2024

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01440	Continued From page 14 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired December 20, 2023, and began providing direct cares for residents on January 23, 2024. On August 27, 2024, at 8:15 a.m., ULP-C was observed administering medications to R3. ULP-C's employee file lacked documentation of direct supervision within 30 days of performing delegated tasks. On August 27, 2024, at 1:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C's record lacked documentation the RN performed a 30-day supervision for a delegated task. The licensee's Supervision of Unlicensed Personnel policy, undated, indicated RN supervision would be completed within 30 calendar days from the day the task was first delegated and would be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36426	A. BUILDING: _____ B. WING _____	08/30/2024

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01640	Continued From page 15 facility shall finalize a current written service plan. (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. (c) The facility must implement and provide all services required by the current service plan. (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. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an 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:	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 16 R1 was admitted March 11, 2024, and had diagnoses including autism. R1's service plan, dated August 26, 2024, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. On August 27, 2024, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with medication administration. R1's record lacked a signed service plan. On August 27, 2024, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated that a signed service plan could not be located and that she had a service planed signed on August 26, 2024, after the start of the survey. The licensee's Service Plan policy, undated, indicated the service plan must include, "a signature or authentication by the a by an assisted living provider and the resident or the residence representative". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/26/24*
Time: 13:30:53
Report: 1050241155

Food and Beverage Establishment Inspection Report

Location:
Suburban Residential Care Llc
7019 Morgan Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0038059
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123809048
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

FACILITY DOES NOT HAVE A CFPM ON SITE. THEY DO HAVE A FOOD MANAGER CERTIFICATE THAT EXPIRES 9/26/26. DISCUSSED MDH REQUIREMENTS AND PROVIDED FACT SHEETS VIA EMAIL. COMPLY WITH RULE ABOVE.

Comply By: 09/27/24

Surface and Equipment Sanitizers

Hot Water: = at 180F Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/Eggs
Temperature: 39F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

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

Inspection was completed by MDH Andrew Spaulding and Hani Issak. Angel Woehler was the lead Health Regulation Division Nurse Evaluator. Facility had three residents on site at time of inspection. Meals are prepared on site and groceries are provided via staff. Discussed dented cans and to check seals to make sure not exposed if so discard.

No noew construction has been completed to residence since ownership. This establishment has a

residential kitchen. The kitchen has wood cabinets with a hollow base and Vinyl Tile flooring, . All found to be in good condition. A two-basin sink is located in the kitchen and a residential dishwasher.

Discussed the following:
-Employee illness policy and logging requirements
-Hand Washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

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 1050241155 of 08/26/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Hani A Issak
Operator

Signed:_____
Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us