Electronically Delivered

October 24, 2024

Licensee
Good Quality Home Health Services
3701 Reservoir Boulevard
Columbia Heights, MN  55421

RE:  Project Number(s) SL33370015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 1, 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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 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 |
|---|---|---|---|
| | 33370 | A. BUILDING: _____ B. WING _____ | 10/01/2024 |

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| GOOD QUALITY HOME HEALTH SERVI | 3701 RESERVOIR BOULEVARD COLUMBIA HEIGHTS, MN 55421 |

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| 0 000 | Initial Comments<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>SL33370015<br><br>On September 30, 2024, through October 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three resident(s); three receiving services under the Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for | 0 470 | | |

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| 0 470 | Continued From page 1<br><br>determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the staffing plan was reviewed twice per year.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when | 0 470 | | |

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| 0 470 | Continued From page 2<br><br>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee held an Assisted Living license, was licensed for a capacity of six residents, and had a current census of three residents.<br><br>During the entrance conference on September 30, 2024, at 10:15 a.m., clinical nurse supervisor (CNS)-A stated one unlicensed personnel was staffed on each of the three shifts per day.<br><br>During the initial tour of the facility with CNS-A on September 30, 2024, at 10:45 a.m., the surveyor observed the facility consisted of a single family style home, with two levels. The lower level consisted of a common area, storage room, office, bathroom, laundry room, and two bedrooms. The upper level consisted of four bedrooms, a bathroom, common area, dining room, and kitchen.<br><br>The licensee's Staffing Plan dated effective August 1, 2021, included a "Date of staffing evaluation" with September 1, 2023 noted, and "Date of next evaluation" August 31, 2024.<br><br>On September 30, 2024, at 1:30 p.m., CNS-A stated she started employment in November of 2023 and was not here to evaluate the plan prior. CNS-A stated she is aware the staffing plan needs to be reviewed twice per year.<br><br>The licensee's Staffing policy dated August 1, 2021, noted the staffing plan was reviewed at least twice a year. | 0 470 | | |

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| 0 470 | Continued From page 3<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br>The findings include:<br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 30, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |

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| 0 485 | Continued From page 4 | 0 485 | | |
| 0 485 SS=C | 144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(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:<br>(A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and<br>(C) the facility cannot require a resident to include and pay for meals in their contract;<br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). | 0 485 | | |

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| 0 485 | Continued From page 5<br><br>The findings include<br><br>R1's Assisted Living Contract dated May 3, 2021, noted in Attachment C Meal Plan Options "Meals are included in Waiver". It noted "My selection of meal plan noted above revokes and replaces any prior meal plan selection. I understand that the fees associated with my selection will be added to my monthly fees."<br><br>On October 1, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated the resident meals are included in the contract, and the same template was utilized for all residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(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.<br>(b) The facility must maintain written evidence of | 0 660 | | |

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| 0 660 | Continued From page 6<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel/ULP-C).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee's TB Risk Assessment dated February 1, 2024, indicated the licensee was a low risk for TB transmission.<br><br>ULP-C was hired on June 20, 2024, to provide direct care services to residents of the facility.<br><br>ULP-C's employee record contained a TST dated read on June 13, 2024. However, the record lacked documented evidence of a second TST as required.<br><br>On October 1, 2024, at 1:10 p.m., clinical nurse supervisor (CNS)-A stated she was only requiring a one step TST, and was not aware of the | 0 660 | | |

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| 0 660 | Continued From page 7<br>requirement to do a two-step TST.<br><br>The licensee's Tuberculosis Screening policy dated August 1, 2021, noted new staff would have a blood test or a two-step Mantoux (TST) conducted with results documented.<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated Baseline TB screening consists of three components:<br>1. Assessing for current symptoms of active TB disease,<br>2. Assessing TB history, and<br>3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA.<br><br>Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following | 0 680 | | |

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| 0 680 | Continued From page 8<br><br>requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and | 0 680 | | |

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| 0 680 | Continued From page 9<br><br>was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the initial tour of the facility with clinical nurse supervisor (CNS)-A on September 30, 2024, at 10:45 a.m., the surveyor observed the facility consisted of a single family style home, with two levels. The lower level consisted of a common area, storage room, office, bathroom, laundry room, and two bedrooms. The upper level consisted of four bedrooms, a bathroom, common area, dining room, and kitchen.<br><br>The licensee's Emergency Procedures binder dated reviewed on August 1, 2024, lacked the following required content:<br>- policy and procedure to address food, medical supplies, pharmaceutical supplies, and safe and sanitary storage of provisions whether evacuated or sheltered in place for staff/residents;<br>- policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records;<br>- policy and procedure to address the use of volunteers, including the process/role for integration;<br>- communication plan including a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care;<br>- communication plan including the means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); | 0 680 | | |

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| 0 680 | Continued From page 10<br><br>- communication plan including the means of providing information about general condition/location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4);<br>- communication plan including a means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and<br>- exercises to test the plan at least twice per year.<br><br>On October 1, 2024, at 9:05 a.m., CNS-A stated the emergency preparedness plan lacked the above required content. In addition, CNS-A stated a tabletop exercise regarding a fire in the kitchen during dinner had been completed on January 1, 2024, but they had not completed twice per year as required.<br><br>Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October, 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 680 | | |

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| GOOD QUALITY HOME HEALTH SERVI | 3701 RESERVOIR BOULEVARD COLUMBIA HEIGHTS, MN 55421 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 780 | Continued From page 11 | 0 780 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 780 | | |

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| 0 780 | Continued From page 12<br><br>resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On October 1, 2024, at 10:30 a.m., survey staff toured the facility with clinical nurse supervisor (CNS)-A. During the tour, the surveyor observed the following:<br>1. A smoke alarm was not installed outside occupied resident bedroom 5 in the immediate vicinity of this sleeping area.<br>2. When smoke alarms were tested for interconnection by the licensee, the smoke alarms installed in bedrooms 3 and 7 were not actuated, and the smoke alarm installed outside occupied bedroom 4 was not actuated. The dwelling unit smoke alarms were not interconnected as required by statute.<br><br>During the facility tour interview on October 1, 2024, CNS-A verified the above listed observations while accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, 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 | 0 800 | | |

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| 0 800 | Continued From page 13<br>repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On October 1, 2024, at 10:30 a.m., survey staff toured the facility with clinical nurse supervisor (CNS)-A. During the tour, the surveyor observed the following:<br>RESIDENT BEDROOMS<br>Unoccupied bedroom 2:<br>- The egress window was difficult to open. Egress windows that do not operate correctly could delay exiting in the event of an emergency.<br>- The window screen was torn.<br>- The vent cover was loose.<br>Unoccupied bedroom 3:<br>- The trim around the egress window was loose.<br>- There was a hole in the back of the bedroom door.<br>Resident occupied bedroom 4:<br>- One burnt cigarette and ashes had been | 0 800 | | |

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| 0 800 | Continued From page 14<br><br>disposed of on the floor. Improper disposal of smoking materials creates a fire hazard.<br>- There were several holes in the wall<br>Resident occupied bedroom 5:<br>- The cover for the light fixture was missing<br><br>INTERIOR<br>1. Main floor storage room (labeled as a bedroom on the floor plan):<br>- A lawn mower, snow blower, and gasoline storage container were stored in this room. Gasoline and gasoline powered equipment must not be stored inside a facility without the required separation between the storage room and dwelling portion of facility building.<br>-There was one unused and uncovered opening in the electrical panel. Electrical panel openings must be properly covered to protect the building occupants from electrical hazards.<br>2. The storm door handle was loose on the side door designated as the secondary emergency exit on the upper level.<br><br>During the facility tour interview on October 1, 2024, CNS-A verified the above listed observations while accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms; | 0 810 | | |

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| 0 810 | Continued From page 15<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 810 | | |

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| 0 810 | Continued From page 16<br><br>safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On October 1, 2024, clinical nurse supervisor (CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br>The undated FSEP floor plans displayed in the facility failed to accurately identify the location and number of resident sleeping rooms. On October 1, 2024, at 10:30 a.m., survey staff toured the facility with CNS-A. During the tour, the surveyor observed the following:<br><br>Room numbers were posted on resident sleeping room doors. The FSEP floor plans did not use number labels for resident sleeping rooms. Resident sleeping room identifiers are required to be included on the fire safety and evacuation floor plan. The identifiers installed on the resident sleeping room doors must correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency.<br><br>The main level floor plan labeled a room as a bedroom but a storage sign was posted on the door for this room. During the facility tour interview on October 1, 2024, CNS-A stated that this room was for storage and not used as a bedroom. FSEP floor plans must be correctly labeled to reduce confusion and potential | 0 810 | | |

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| 0 810 | Continued From page 17<br><br>obstructions to egress in a fire or similar emergency.<br><br>During the facility tour interview on October 1, 2024, CNS-A verified the FSEP floor plans required revision.<br><br>TRAINING<br>Record review indicated the licensee failed to provide documentation to support FSEP training had been completed with employees at least twice per year. The FSEP employee training records provided did not list the dates this training had been completed. During an interview on October 1, 2024, at 12:35 p.m., CNS-A stated employees completed FSEP training in January and August 2024.<br><br>Record review indicated the licensee failed to provide documentation to support fire safety and evacuation training had been completed with residents at least once per year. A fire safety and evacuation training record for residents dated January 1, 2024, was provided. The last names had not been recorded for two of the training participants.<br><br>During an interview on October 1, 2024, at 12:35 p.m., CNS-A verified the training documentation did not include the required information.<br><br>DRILLS<br>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift evident by a review of completed drill records lacking the required frequency. Seven fire drills were recorded in the past year. Five of these drills were completed during the morning shift and two during the afternoon shift. No night shift fire drills had been completed in the | 0 810 | | |

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| 0 810 | Continued From page 18<br>last year. During an interview on October 1, 2024, at 12:35 p.m., CNS-A stated the licensee had three shifts for employees and verified night shift drills had not been completed.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 940 SS=C | 144G.50 Subd. 2 (e; 5-7) Contract information<br><br>(5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:<br>(i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;<br>(ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);<br>(iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;<br>(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;<br>(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;<br>(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and<br>(vii) a description of the rent requirements for people who are eligible for medical assistance | 0 940 | | |

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| 0 940 | Continued From page 19<br><br>waivers but who are not eligible for assistance through the housing support program;<br>(6) the contact information to obtain long-term care consulting services under section 256B.0911; and<br>(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1).<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1's undated Assisted Living Contract lacked the following required content:<br>- whether the facility had an agreement to provide housing support under section 256I.04, Subd. 2, paragraph (b);<br>- whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;<br>- whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; | 0 940 | | |

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| 0 940 | Continued From page 20<br><br>- a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;<br>- a statement that residents may be eligible for assistance with rent through the housing support program; and<br>- a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program.<br><br>On October 1, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated the contract contained the exact verbiage from the regulation, but was not individualized to the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 940 | | |
| 01650 SS=F | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(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;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the | 01650 | | |

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| 01650 | Continued From page 21<br><br>facility;<br>(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<br>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a service plan included the required content for one of one resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1's Service Plan dated February 24, 2022, indicated R1 received services including medication administration. However, it lacked:<br>- the methods of monitoring assessments of the resident;<br>- the methods of monitoring staff providing services;<br>- identification of and information as to who has | 01650 | | |

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| 01650 | Continued From page 22<br><br>authority to sign for the resident in an emergency; and<br>- the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>On September 30, 2024, at 2:25 p.m., clinical nurse supervisor (CNS)-A stated the service plan lacked the above required content. CNS-A stated the service plan did note the resident had not executed a Health Care Directive.<br><br>The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include a schedule and method for the next planned assessment or monitoring, a schedule and method for the next planned monitoring of staff providing services, a contingency plan including how the facility would support documented resident health care directive decision,s if any, including circumstances when emergency medical services are not to be summoned.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01650 | | |
| 01750 SS=D | 144G.71 Subd. 7 Delegation of medication administration<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; | 01750 | | |

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| 01750 | Continued From page 23<br><br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure as needed (PRN) medications included parameters for administration for one of one resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's record lacked specific written instructions regarding the administration of PRN medication ordered with a dosage range.<br><br>R1's diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).<br><br>R1's Service Plan dated February 24, 2022, indicated R1 received services including medication management.<br><br>R1's prescriber orders dated March 19, 2024, included:<br>- acetaminophen 500 milligrams (mg) Take 1-2 | 01750 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD QUALITY HOME HEALTH SERVI | 3701 RESERVOIR BOULEVARD COLUMBIA HEIGHTS, MN 55421 |

| (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 |
|---|---|---|---|---|
| 01750 | Continued From page 24<br>tablets by mouth every 6 hours as needed for pain.<br><br>On September 30, 2024, at 2:25 p.m., clinical nurse supervisor (CNS)-A stated the acetaminophen order did contain a range without parameters when to give one tablet and when to give two tablets.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01750 | | |
| 01760 SS=D | 144G.71 Subd. 8 Documentation of administration of medication<br><br>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 with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to verify accuracy of prescriber orders when transcribing orders for one of one residents (R1). | 01760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 33370 | A. BUILDING: _____ B. WING _____ | 10/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD QUALITY HOME HEALTH SERVI | 3701 RESERVOIR BOULEVARD COLUMBIA HEIGHTS, MN 55421 |

| (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 |
|---|---|---|---|---|
| 01760 | Continued From page 25<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).<br><br>R1's Service Plan dated February 24, 2022, indicated R1 received services including medication management.<br><br>R1's prescriber orders dated July 23, 2024, noted:<br>- clonidine 0.3 milligrams (mg) every 8 hours as needed.<br><br>R1's September 2023 Medication Administration Report noted:<br>- clonidine 0.3 mg take one tablet by mouth every 6 hours as needed.<br><br>On September 30, 2024, at 2:25 p.m., clinical nurse supervisor (CNS)-A stated the transcription of the order did not match the prescriber order as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/30/24*
Time: 12:00:00
Report: 1025241193

# Food and Beverage Establishment Inspection Report



**Location:**
Good Quality Home Health Servi
3701 Reservoir Boulevard
Columbia Heights, MN55421
Anoka County, 02

**Establishment Info:**
ID #: 0038900
Risk:
Announced Inspection: Yes

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6127015965
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.

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

Remove or replace multi-use utensils which are damaged and/or not often use with utensils which can be scoured when cleaning
Upstairs refrigerator 41 deg F inside, non-TCS food in door at 45 deg F. Store TCS foods in center fridge
Downstairs refrigerator 38 deg F

FACILITY
Appliances are residential
Food thermometer, dish washer min/max and test strips available

SINK USAGE
Facility has a two (2) compartment sink and a stand alone (1) compartment sink
Facility has a dishwasher with a sanitize cycle
Facility does not have a 3 compartment sink
Facility does not have a dedicated food preparation sink

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

DISHWASHING - NSF 184
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) - use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher

If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)
Recommend having an alternative means of sanitizing available case of emergency or service interruption

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), chemical label, use, and storage, pest control, quarantine meals

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page
"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

Type: Full
Date: *09/30/24*
Time: 12:00:00
Report: 1025241193
Good Quality Home Health Servi

# Food and Beverage Establishment Inspection Report

**NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.**

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025241193 of 09/30/24.

Certified Food Protection Manager: Zahra Yousuf

Certification Number: FM124106 Expires: 05/25/27

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

Signed:_____
Establishment Representative

Signed:_____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us