Electronically Delivered

July 21, 2023

Licensee
Caring Nurses LLC
7715 Brooklyn Boulevard
Brooklyn Center, MN 55443

RE: Project Number(s) SL33553015

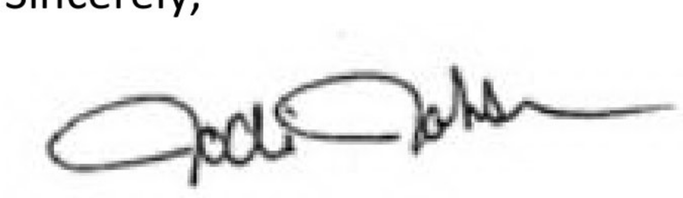
Dear Licensee:

On July 19, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 1, 2023, 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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

Electronically Delivered

June 30, 2023

Licensee
Caring Nurses LLC
7715 Brooklyn Boulevard
Brooklyn Center, MN 55443

RE: Project Number(s) SL33553015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 . . ."

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and

submit information supporting your position(s).
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

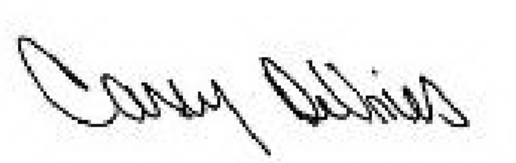
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33553	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7715 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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: SL33553015-0 On May 30, 2023, through June 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five active residents receiving services under the Assisted Living license. An immediate correction order was identified on May 31, 2023, issued for SL33553015-0, tag identification 2310. The immediacy for the correction order identified on May 31, 2023, issued for SL33553015-0, tag identification 2310, was removed as of June 1, 2023. The scope and level remain unchanged.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 included document titled, Food and Beverage Establishment Inspection Report dated May 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in	0 510		

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0 510	Continued From page 2 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control for one of three employees (unlicensed personnel (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) 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: ULP-C was hired on November 8, 2021. ULP-C's training transcript indicated ULP-C completed training related to infection control on October 24, 2022. On May 31, 2023, at 7:17 a.m., the surveyor observed ULP-C performing a bed bath on R3 from head to toe. ULP-C started from the face working to the stomach area before assisting R3 turn to his side to wash the back. ULP-C completed perineal cares on R3 working from back to front, then ULP-C completed the bed bath working from groin to lower extremities while using the same washcloth.	0 510		

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0 510	Continued From page 3 On May 31, 2023, at 7:30 a.m., ULP-C stated he had been working as a personal care assistant (PCA) for "several years". ULP-C also stated that their training related to cares was completed by nursing personnel on site. On May 31, 2023, at 10:30 a.m., clinical nurse supervisor (CNS)-A stated all staff are trained on infection control measures at orientation and thereafter annually to ensure the residents are free from infections. The licensee's undated Standard Precaution for all Health Care Workers policy indicated gloves, such as vinyl or latex medical gloves, must be worn when cleaning resident rooms, bathrooms, emptying trash, or changing linens on resident's bed. The policy lacked a procedure for a bed bath. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult	0 550		

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0 550	Continued From page 4 Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all five 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 May 30, 2023, at 11:08 a.m., during a facility tour, the surveyor observed the common areas shared by residents, staff and visitors lacked the required posting of the grievance procedure with the following information: - the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances; - contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center;	0 550		

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0 550	Continued From page 5 and - state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. On May 30, 2023, at 11:15 a.m., clinical nurse supervisor (CNS)-A verified the common areas lacked a grievance procedure posting with required content. CNS-A stated the licensee provided each resident with a complaint form when contracts were signed. CNS-A also stated the licensee had received and filed all grievances from residents. The licensee's undated Complaint and Investigation Process policy, indicated residents will be informed of their right to complain to the facility about the services received and of the process to follow when making a complaint to the provider. Residents and their representatives will be informed that complaints may be made without fear of discrimination and/or retaliation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630		

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0 630	Continued From page 6 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) was developed to include the required content for one of two 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: R1's diagnoses included bipolar disorder, mania with grandiosity, diabetes mellitus type 2, and major depression. R1's Service Plan (Waiver)- Addendum to Contract dated June 20, 2022, indicated R1 received following services blood glucose monitoring, medication management, wound care, and bathing assistance. R1's IAPP dated May 2, 2023, indicated R1 had the following vulnerabilities: gait imbalance, unsteady gait, history of alcohol abuse, wandering, physical aggression, and verbal	0 630		

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0 630	Continued From page 7 aggression. R1's IAPP lacked the following content: - 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 specific measures to be taken to minimize the risk of abuse. On May 31, 2023, at 11:45 a.m.,registered nurse (RN)-B stated the vulnerability assessment lacked identified content above and stated the software licensee used did not give them the options for the content above. The licensee's undated Abuse Prevention Plan policy indicated all residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. This includes self-abuse. The plan will be incorporated into the resident care plan and will reflect their ability to participate in and direct their own care in the presence of an identified caregiver. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 8 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment worksheet dated August 1, 2021, indicated the licensee's setting was a low risk for TB, also	0 660		

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0 660	Continued From page 9 indicated TB risk assessment will be conducted or updated annually. The licensee's TB facility risk assessment had not been updated for the current year 2022- 2023. On May 31, 2023, at 12:20 p.m., clinical nurse supervisor (CNS)-A stated they were aware licensee had not updated the TB facility risk assessment as required. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "each provider licensed by MDH is required to complete a TB risk assessment annually. Completion of this assessment will assist providers in the development of an infection control committee and in determining the frequency of screening." The licensee's undated Tuberculosis Prevention and Control policy indicated facility will establish a protocol for early identification of individuals with active tuberculosis. The policy did not address how licensee would maintain the TB risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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0 680	Continued From page 10 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 plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. 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).	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33553	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 680	Continued From page 11 The findings include: On May 30, 2023, at 11:00 a.m., clinical nurse supervisor (CNS)-A provided emergency disaster preparedness plan. The licensee's emergency disaster preparedness plan was in a template format with blank lines that the licensee had left incomplete and undated. The licensee's emergency disaster preparedness plan lacked the following required content: - Procedures for tracking of Staff and Patients; - Policies and Procedures for Medical Documentation; - Policies and Procedures for Volunteers; - Roles under a Waiver Declared by Secretary; - Primary/Alternate Means of Communication; - Methods for Sharing Information; - Sharing information on Occupancy/Needs; - Emergency Prep Training and Testing; and - Emergency Prep Training Program. On June 1, 2023, licensed assisted living director (LALD)-F stated licensee was aware the EPP was lacking content and was working closely with a consultant to have it updated. The licensee's undated Emergency Management Policy indicated licensee will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 12	0 780		
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: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm causes all alarms to actuate, sounding throughout the home. This has the potential to directly affect the residents, visitors, and staff. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 13 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 May 31, 2023, approximately from 1:40 p.m. to 2:30 p.m., survey staff toured the home with the director of maintenance (DM)-G. During the tour, survey staff observed the smoke alarms in the home failed to interconnect all required smoke alarms to sound throughout the home for proper notification. The findings were evident when the smoke alarms that were located outside main-level hallways next to resident bedrooms #5 and #6, and the lower-level common area sounded local when the DM-G activated each smoke alarm during the home tour. The DM-G pulled the hallway smoke alarm from its housing next to resident bedroom #5 exposing the wires in the ceiling and found out the smoke alarms were of battery-operated type only and can't be connected to the wire. Survey staff explained to the DM-G that the smoke alarms outside the vicinity of bedrooms #5 and #6 are hardwired-type and must be installed with hardwired-type of smoke alarms and not battery-type smoke alarms. Survey staff also clarified to the DM-G that the correct installation of a smoke alarm in the home is when one smoke alarm in the home is activated, all smoke alarms must actuate to sound throughout for notification regardless of the type of smoke alarms installed in the home. The findings were verbally and/or physically	0 780		

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0 780	Continued From page 14 verified by the DM-G accompanying the tour. On May 31, 2023, at approximately 3:30 p.m., at the exit interview, the clinical nurse supervisor (CNS)-A acknowledged the above findings. During the exit interview, survey staff tested a smoke alarm in the lower-level common area to explain to the CNS-A that the smoke alarm failed to meet the requirement of interconnection of all smoke alarms in the home since it only sounded local when activated and did not activate any other smoke alarms in the home. The CNS-A stated she understands. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and	0 790		

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0 790	Continued From page 15 interview, the licensee failed to provide the minimum required size and to maintain the portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 May 31, 2023, approximately from 1:40 p.m. to 2:30 p.m., survey staff toured the home with the director of maintenance (DM)-G. Survey staff observed the following findings during the home tour: -The portable fire extinguisher did not meet the required minimum rated type, 2-A:10-B:C. Survey staff observed the label on the mounted unit in the kitchen and throughout the home with the incorrect size unit with rating type 1-A:10-B:C. -The portable fire extinguishers were observed with no tag attached to indicate the required annual service and monthly quick inspections from this year, or any previous years. The listed findings were verbally and physically verified by the DM-G accompanying the tour. On May 31, 2023, at approximately 3:30 p.m., at the exit interview, the clinical nurse supervisor-A acknowledged the above findings.	0 790		

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0 790	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 May 31, 2023, at approximately from 1:30 to	0 800		

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0 800	Continued From page 17 1:40 p.m. survey staff toured the home with the unlicensed personnel (ULP)-D. At approximately 1:40 p.m. the ULP-D left the tour and from 1:40 p.m. to 2:30 p.m., survey staff toured the home with the director of maintenance (DM)-G. During the tours, survey staff observed the following: -Inside bedroom #1, the egress window failed to open when the ULP-D attempted. In addition, the door hardware was broken and failed to latch when closed. The ULP-D verified the findings and also stated that the DM-G can open the egress window when they arrived. -The main-level door near the ramp (next to bedroom #6) which exits to the outside of the home failed to latch, close, and lock properly for the safety of residents. Survey staff observed door hardware was broken or compromised and explained to the DM-G that this can be a security issued for both staff and residents. The DM-G stated the door is being replaced. -Resident bedroom #5 was missing a window screen to prevent insects into the room and home when opened. -The lower-level bathroom was missing an exhaust fan cover. -The propane tank and oxygen cylinders were stored in the common areas of the lower-level floor. The DM-G had her assistant remove the propane tank while on tour. -No approved smoke cigarette butt receptor was provided outside near the smoking area. Survey staff observed cigarette butts inside the planters and a container in front of the home. The listed findings were verbally and/or physically verified by the DM-G accompanying the tour. On May 31, 2023, at approximately 3:30 p.m., at the exit interview, the clinical nurse supervisor-A	0 800		

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0 800	Continued From page 18 acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 19 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, document review, and interview, the licensee failed to have the required fire safety and evacuation plan that is readily available at the home, all required contents on the fire safety and evacuation plan, the minimum required training on the fire safety and evacuation plan, and the minimum required evacuation drills. This has the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care. 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 May 31, 2023, approximately from 1:40 p.m. to 2:30 p.m., survey staff toured the home with the director of maintenance (DM)-G. On May 31, 2023, at approximately 2:30 p.m., survey staff requested from the clinical nurse supervisor- (CNS)-A for the home's fire safety and evacuation plan and related documentation. The CNS-A explained she will need to contact the office for a copy of the plan as they currently are working hard on updating the emergency	0 810		

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0 810	Continued From page 20 preparedness plan. At approximately 3:00 p.m., the CNS-A printed a copy of the emergency preparedness plan with the fire safety and evacuation plan (dated as printed May 31, 2023). Document review and interview with the (CNS)-A at approximately 3:15 p.m. indicated the following: -The licensee lacked the required fire safety and evacuation plan that is readily available at the home. The licensee is required to maintain accurate fire safety and emergency evacuation plan and is readily available on-site at the home. -The posted home layout plans for the main-level floor lacked resident room locations. The CNS-A verified the finding and agreed to revise the plan to identify bedrooms #1 through #6. -The lower-level floor plan layout incorrectly labeled a storage room as a "bedroom". The DM-G stated that the room is not a bedroom and is only used for storage and will be converted into an office. -The home's fire safety plan lacked site-specific fire protection procedures for employees. The documentation incorrectly stated that the home was provided with a fire suppressant system and indicated the locations of the sprinklers. -The plan documentation lacked fire protection procedures for residents. - The plan documentation did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Survey staff explained that unique situations or logistics during an evacuation may be residents who have mobility limitations, non-ambulatory, or any residents needing additional assistance during an evacuation that must be addressed in the fire safety and evacuation plan documentation.	0 810		

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0 810	Continued From page 21 During the interview, the CNS-A verified that the fire safety and evacuation plan for the facility lacked these provisions. -No documentation or records to show employee training on the facility fire safety and evacuation plan upon hiring of the employees and at least twice per year thereafter. Documentation was requested and none was available or provided for review. -No documentation or records to show training of residents that can self-assist in their evacuation during the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. Documentation was requested and none was available or provided for review. -No fire evacuation drill records were available or provided for review. Survey staff requested documentation and no records were provided for review. Survey staff explained to the CNS-A the minimum number of required evacuation drills that must be performed by employees is upon hire and twice per year per shift, thereafter, with at least one evacuation drill every other month, for a minimum total of six evacuation drills per year. Documentation was requested and none was available or provided for review. On May 31, 2023, at approximately 3:30 p.m., at the exit interview, the CNS-A acknowledged the above findings. Survey staff explained that the floor plan be updated to remove the "bedroom" from the plan and the CNS-A agreed. She also explained that their office was working with consultants on updating their fire safety and evacuation plan and the emergency preparedness plan. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen	0 810		

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0 810	Continued From page 22 (14) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 900		

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0 900	Continued From page 23 licensee failed to develop and execute a written contract with the required content for one of two residents (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) 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 was admitted on January 26, 2023, for assisted living services. R3's undated and unsigned Service Plan (Waiver) - Addendum to Contract, indicated R3 received services including medication administration, bathing assistance, mobility assistance, and behavior management. R3's Resident Agreement dated January 26, 2023, lacked a written signature by R3 and licensee's representative prior to receiving assisted living services. On June 1, 2023, at 10:40 a.m., licensed assisted living director (LALD)-F stated the contract was not signed because R3 could not write. Also, LALD-F stated licensee was in the process to petition the court to give R3 a guardian to sign documents. R3's record lacked documented evidence of R3's inability to sign and of R3's verbal agreement to the services being provided by licensee.	0 900		

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0 900	Continued From page 24 The licensee's undated Assisted Living Contracts policy indicated licensee will establish a contract with each resident at the time of admission to the program. The contract will be inclusive of both the tenant-landlord relationship and the services to be provided. Prospective residents will receive an unsigned copy of the contract and an unsigned copy will be provided for the Office of the Ombudsman for Long-Term. Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for	0 950		

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	33553	A. BUILDING: _____ B. WING _____	06/01/2023

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0 950	Continued From page 25 the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete documentation for the opportunity to identify a designated representative in writing by not requiring the contract section to be filled out, for one of two 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) 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: R1 admitted to the licensee on February 8, 2019, under the former comprehensive license and transitioned to assisted living August 1, 2021. R1's resident contract dated November 22, 2021, included a page to designate a representative, however, was left blank and lacked acknowledgment of the resident to indicate if they declined to name a designated representative, or chose to name a representative. On June 1, 2023, at 10:30 a.m., licensed assisted	0 950		

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0 950	Continued From page 26 living director (LALD)-F stated the residents do not have next of kin as most of them came from the street. LALD-F further stated licensee had not given opportunity to their residents to decline to name a designated representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessments within the required timeframe for two of two residents (R1 and 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) 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: R1 R1 admitted to the licensee on February 8, 2019, under the former comprehensive license and transitioned to assisted living August 1, 2021. R1's diagnoses included bipolar disorder, mania with grandiosity, diabetes mellitus type 2, and major depression. R1's Service Plan (Waiver)- Addendum to Contract dated June 20, 2022, indicated R1 received following services: blood glucose monitoring, medication management, wound care, and bathing assistance. R1's record included 90-day nursing assessments completed September 1, 2022, December 5, 2022, and April 19, 2023. The assessments were over the 90-day timeframe by five days and 45 days.	01620		

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01620	Continued From page 28 R3 R3 was admitted on January 26, 2023, for assisted living services. R3's diagnoses included multiple sclerosis, chronic bilateral low back pain with right-sided sciatica, cerebrovascular accident, and gait instability. R3's undated and unsigned Service Plan (Waiver) - Addendum to Contract, indicated R3 received services including medication administration, bathing assistance, mobility assistance, and behavior management. R3's record included an initial assessment completed January 26, 2023, and a 14-day assessment completed February 15, 2023, which was six days late. On May 31, 2023, at 12:40 p.m., registered nurse (RN)-B stated licensee was aware resident assessments were done late, as licensee did not have a system in place to track the assessments. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the licensee will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier. Also indicated Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information provided.	01620		

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01620	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include all the required content one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01910		

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01910	Continued From page 30 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 discharged from assisted living services November 28, 2022. R2's Service Plan (Waiver)- Addendum to Contract dated June 23, 2022, indicated R2 received medication administration. R2's undated Discharge - Transfer Summary indicated R2 received the following medications: Lantus Solostar 100 units/milliliter (u/ml) inject 23 units subcutaneously daily, lisinopril-hydrochlorothiazide 20-12.5 milligram (mg) give two tablets every morning, metoprolol suc 200 mg tablets give one tablet by mouth every morning, Novolog flexpen 100 u/ml inject as directed per sliding scale, trazodone 50 mg take one tablet by mouth at bedtime, warfarin 2.5 mg take one tablet by mouth daily, and acetaminophen 500 mg take 1-2 tablets by mouth every six hours as needed. R2's record lacked a medication disposition record with required content to include: - medication's name; - strength; - prescription number as applicable; - quantity; - to whom the medications were given; - date of disposition; and - names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 31 On May 31, 2023, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated R2 received medication management services, and upon discharge the licensee completed a disposition record on paper and put away in storage but they could not find it. The licensee's undated Medication Disposal policy indicated licensee will develop policies to be followed in disposing of medications that are no longer used or after the resident has been discharged or has died. Facility staff will have guidelines to follow and will contact RN if there are questions or concerns. The policy also indicated all the missing content will be included in resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy	01940		

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01940	Continued From page 32 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan (ITMP) to include all required content for one of one resident (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) 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: R1 admitted to the licensee on February 8, 2019, under the former comprehensive license and transitioned to assisted living August 1, 2021.	01940		

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01940	Continued From page 33 R1's diagnoses included R1's diagnoses included bipolar disorder, mania with grandiosity, diabetes mellitus type 2, and major depression. R1's Service Plan (Waiver)- Addendum to Contract dated June 20, 2022, indicated R1 received the following prescribed treatments or therapies: blood glucose monitoring and oxygen. R1's Blood Glucose/Insulin Flow Sheet dated May 1, 2023, through May 30, 2023, indicated R1's blood glucose ranged between 58 and 353 milligram/deciliter (mg/dl). On May 31, 2023, at 9:20 a.m., the surveyor observed ULP-D administer R1's medication, check R1's blood glucose and prepare R1's insulin pens before handing them to R1 for self-administration. On May 31, 2023, the surveyor reviewed the following of R1's records: medication administration (MAR), blood glucose/insulin flow and 90-day nursing assessments, and the following information was found nowhere in R1's record: - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 31, 2023, at 11:20 a.m., clinical nurse	01940		

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01940	Continued From page 34 supervisor (CNS)-A stated licensee used paper charting for ITMP but could not them find for any of the residents with treatments. The licensee's undated Treatment and Therapy Management Plan policy indicated the individualized plan for each resident receiving treatment or therapy services will be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. The policy also indicated the missing content above will be included. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for one of two residents (R5) who utilized bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	02310	The immediacy for the correction order identified on May 31, 2023, issued for SL33553015-0, tag identification 2310, is removed as of June 1, 2023. The scope and level remain unchanged.	

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02310	Continued From page 35 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 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: R5 admitted to the licensee on February 8, 2019, under the former comprehensive license and transitioned to assisted living August 1, 2021. R5's diagnoses included malignant neoplasm/breast, diabetes mellitus type 2, lower extremity weakness in both lower extremities, and failure to thrive in adult. R5's unsigned Service Plan dated March 23, 2023, indicated R5 received the following services: medication administration, blood glucose, transfer assistance, and bathing assistance. On May 31, 2023, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare and administer medication to R5, and prepare insulin for R5 to self-administer in his room. The surveyor observed R5's hospital bed had bilateral rectangular bed rails measuring approximately 32 inches long by 15 inches tall. The middle space of the bed rails each had 10 vertical bars which were approximately four inches apart. R5's assessment dated September 22, 2022, indicated R5 had an electric hospital bed with bed safety zones: "zone 1 area within the rail less than four and three quarter inches, zone 2 area under the rail, between rail supports or next to a	02310		

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02310	Continued From page 36 single rail support less than four and three quarter inches, and zone 3 area between the rail and mattress less than four and three quarter inches". R5's assessment dated April 17, 2023, indicated R5 had an electric hospital bed with bed safety with "zone 3 area between the rail and mattress less than four and three quarter inches". R5's record lacked consistent nursing assessment with following bed rail information: - purpose and intention of the bed rail; - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion documented; - the resident's preferences; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The FDA, A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's	02310		

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02310	Continued From page 37 cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On May 31, 2023, at 12:26 p.m., registered nurse (RN)-B stated licensee did not have benefit verses risk acknowledgment documented but stated will call LALD-F to confirm. LALD-F stated was not sure they completed benefit verses risk assessment. The licensee's undated, Use of Side Rails policy indicated side rails will not be used in the assisted living setting except in situations where assessment determines they are necessary for safety of the resident. If the resident or resident's representative wants side rails on the bed, facility RN will educate the resident/representative about	02310		

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02310	Continued From page 38 the risks related to side rails and will assess whether the side rails meet FDA standards. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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

Type: Full
Date: *05/30/23*
Time: 13:36:02
Report: 1004231034

Food and Beverage Establishment Inspection Report

Location:
Caring Nurses Llc
7715 Brooklyn Boulevard
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038880
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635664325
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISH MACHINE IS NOT REACHING A MINIMUM OF 160*F UTENSIL SURFACE TEMPERATURE FOR SANITIZING. SERVICE MACHINE IMMEDIATELY AND USE A CHEMICAL SANITIZER UNTIL MACHINE CAN BE REPAIRED.

Comply By: 05/30/23

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE TEMPERATURE INDICATOR FOR USE WITH THE HIGH-TEMPERATURE DISH MACHINE. PROVIDE AND USE FREQUENTLY TO ENSURE A UTENSIL SURFACE TEMPERATURE OF 160*F IS REACHED FOR SANITIZING. *THERMOLABELS LEFT ON SITE FOR USE.

Comply By: 05/30/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO SANITIZER TEST KIT FOR CHLORINE (BLEACH). PROVIDE AND USE FREQUENTLY TO ENSURE A CONCENTRATION OF 50-100PPM IS MAINTAINED FOR FOOD-CONTACT SURFACE SANITIZING.

Comply By: 05/30/23

2-100 Supervision

2-102.12AMN

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

NO CURRENT STATE CERTIFIED FOOD PROTECTION MANAGER. STAFF MEMBER IS IN THE PROCESS OF COMPLETING COURSE AND WILL APPLY WITH THE STATE ONCE COMPLETED.

Comply By: 05/30/23

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO INTERNAL THERMOMETER LOCATED IN THE REFRIGERATOR. PROVIDE AND LOCATE IN THE WARMEST PART (NEAR THE DOOR).

Comply By: 05/30/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISH MACHINE IS UNABLE TO REACH A UTENSIL SURFACE SANITIZING TEMPERATURE OF AT LEAST 160*F. HAVE UNIT SERVICED IMMEDIATELY OR REPLACE. USE A CHEMICAL SANITIZER (CHLORINE BLEACH, CONCENTRATION OF 50-100PPM) UNTIL MACHINE IS REPAIRED AND VERIFIED.

Comply By: 05/30/23

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

OBSERVED FOOD DEBRIS/RESIDUES AROUND THE GASKET ON THE CHEST FREEZER. CLEAN THOROUGHLY AND MAINTAIN.

Comply By: 05/30/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO POSTER/SIGN AT DESIGNATED HANDWASHING SINK. PROVIDE AND MAINTAIN.

Comply By: 05/30/23

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	2	5

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY BENARD NYANGENA.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-PREVENTING BAREHAND CONTACT
-SANITIZER USE AND TEST KITS
-DISH MACHINE SANITIZING TEMPERATURE VERIFICATION
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES (SAME-DAY PREP AND SERVE)
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE
-ALL VIOLATIONS ON THIS REPORT

*THERMOLABELS LEFT ON SITE FOR ESTABLISHMENT TO USE AND SEND RESULTS TO INSPECTOR. RESULTS WERE PROVIDED TO INSPECTOR ON 6/1/23 AND IT WAS FOUND THAT THE DISH MACHINE WAS NOT REACHING A REQUIRED UTENSIL SURFACE TEMPERATURE

OF AT LEAST 160*F. INSPECTOR INSTRUCTED THE LALD TO USE A CHEMICAL SANITIZER (CHLORINE BLEACH), RATED FOR FOOD-CONTACT SURFACES, AT A CONCENTRATION OF 50-100PPM, SUBMERGED FOR THE AMOUNT OF TIME LISTED ON THE CONTAINER, AND AIR DRIED. ESTABLISHMENT WILL FOLLOW-UP WITH INSPECTOR WHEN MACHINE IS SERVICED AND VERIFY THAT SANITIZING TEMPERATURES ARE REACHED.

*FLOORS ARE STONE TILE. WALLS AND CEILING ARE SMOOTH PAINTED DRYWALL. CABINETS ARE VARNISHED WOOD. 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.

*REPORT WAS DISCUSSED WITH MANAGEMENT AND EMPLOYEES ON SITE AND WITH THE NURSE EVALUATOR, BENARD.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 1004231034 of 05/30/23.

Certified Food Protection Manager: NONE

Certification Number: _____ Expires: / /

Signed: _____
BRANDI STAMPER

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
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