DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 7, 2023

Licensee
Attentive Care
3524 Kyle Avenue North
Crystal, MN 55422

RE: Project Number(s) HL355465817C; HL355463543M; SL35546015

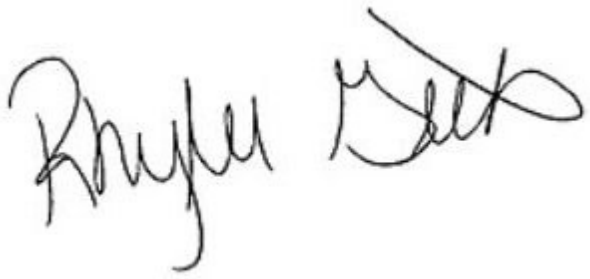
Dear Licensee:

On January 5, 2023, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for complaint investigation HL355465817C/HL355463543M and survey SL35546015. Attentive Care was found to be in substantial compliance with state regulations for the two follow-up surveys.

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

Please feel free to call me with any questions.

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 218-232-8285 Fax: 651-281-9796

PMB

AMENDED TO INCLUDE TAG 1620

Electronically Delivered

December 27, 2022

Licensee
Attentive Care
3524 Kyle Avenue North
Crystal, MN 55422

RE: Project Number(s) SL35546015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on November 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The initial letter that you received pertaining to this evaluation was inadvertently missing tag 1620 as well as the associated fine of $3,000. You will find the tag and fine underlined below. **This change is related to tag 1620 only, and does not change the time period for correction or the timelines for requesting reconsideration or a hearing on any other correction order.**

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

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

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

authorized in § 144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required = $500
St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders = $3,000
St - 0 - 0490 - 144g.41 Subd 1 (13) (ii)-(vii) - Minimum Requirements = $3,000
St - 0 - 1390 - 144g.62 Subdivision 1 - Availability Of Contact Person To Staff = $3,000
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring = $3,000

The total amount you are assessed is ~~$9,500~~ $12,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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 Department of Health within 15 business days of the correction order receipt date. 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35546	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE CARE	3524 KYLE AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35546015-0 On November 07, 2022, through November 09, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents receiving services under the provider's Assisted Living Facility license. On November 08, 2022, at 4:30 p.m., an immediate order was issued for 1620. On November 09, 2022, at 1:30 p.m., an immediate order was issued for 1390 On November 09, 2022, the time of exit at 3:10 p.m., the immediacies of 1620 and 1390 were not removed.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee with Board of Executives for Long-Term Services and Support (BELTSS) website. This had the potential to affect all the licensee's 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 November 7, 2022, at 10:00 a.m. registered nurse (RN) identified themselves as LALD (LALD/RN)-A for the facility. Review of the BELTSS website at the time, indicated LALD/RN-A held a current LALD license. The BELTSS website did not identify LALD/RN-A was listed as the Director of Record for the licensee. On November 7, 2022, at 10:15 a.m. LALD/RN-A verified they were not listed as the Director of	0 110		

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0 110	Continued From page 2 Record for licensee. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;	0 250		

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0 250	Continued From page 3 (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; in addition, the licensee failed to develop and/or implemented current policies and procedures as required. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 250		

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0 250	Continued From page 4 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 had an Assisted Living Facility license issued on August 1, 2022, with an expiration date of July 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - delegation of tasks by registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. The licensee's Application for Assisted living License signed May 17, 2021, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), indicated, "I certify I have read and understand the following:" A check mark, indicating understanding, was placed before each of the following: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.	0 250		

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0 250	Continued From page 5 - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted	0 250		

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0 250	Continued From page 6 are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner, who was also the unlicensed personal (O/ULP)-D on May 17, 2021. The licensee's renewal application signed by O/ULP-D on May 13, 2022, also indicated check marks attesting O/ULP-D understood Assisted Living Licensure laws, rules and statutes, as listed above. The renewal application further indicated O/ULP-D understood O/ULP-D was "legally responsible for the management, control, and operation of the facility, regardless of the	0 250		

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0 250	Continued From page 7 existence of a management agreement or subcontract." During the entrance conference on November 07, 2022, at 10:00 a.m., the licensed assisted living director, who was also the registered nurse (LALD/RN)-A, and housing manager, who was also the unlicensed personal (HM/ULP)-B, stated they were in charge of the day-to-day operations of the facility and were familiar with the regulations for an Assisted Living Facility license. LALD/RN-A further stated the licensee provided the following services: medication and treatment management, staff orientation and training, and delegation of tasks by the RN to ULPs. The licensee failed to implement the corresponding policies and procedures, as required. As a result of this survey, 16 correction orders were issued: 0110, 0250, 0340, 0460, 0470, 0480, 0490, 0570, 0580, 0630, 0680, 0780, 0790, 0800, 0810, 0900, 1390, 1620, 1650, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The	0 340		

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0 340	Continued From page 8 correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the following immediate correction orders identified during a survey: tag identification 0110, identified August 8, 2022, and tag identification 1620 and 1390, identified November 8- 9, 2022. This had the potential to affect all three residents and staff in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 340		

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0 340	Continued From page 9 has affected or has potential to affect a large portion or all of the residents). The findings include: On November 8, 2022 at 4:30 p.m., an immediate order was issued via email for order number 1620. The email included a request for a reply to confirm receipt, as well as to submit a plan to remove the immediacy of the order. On November 9, 2022 at 9:00 a.m., the owner, who was also the unlicensed personal (O/ULP)-D, emailed the survey supervisor, in reply to the previous message, and provided additional documentation related to the immediate correction order 1620. The licensee failed to provide a plan to remove immediacy. On November 9, 2022 at 10:00 a.m., the survey supervisor replied to O/ULP-D via email, acknowledging receipt of the provided document, identified the plan was insufficient and indicted the immediacy would not be lifted. Further, the survey supervisor again requested the licensee's plan to address the immediate order 1620. On November 9, 2022, at 1:30 p.m., an immediate correction order was issued via email for order number 1390. The correction order included the previously identified immediate order 1620, and indicated the order had been revised (the severity was increased to level 3). The email included a request for a reply to confirm receipt as well as to submit a plan to remove immediacy. On November 9, 2022, at 2:50 p.m., O/ULP-D submitted a correction plan in regards to immediate orders 1620 and 1390. The plan was found to be insufficient, and the survey supervisor	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35546	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE CARE	3524 KYLE AVENUE NORTH CRYSTAL, MN 55422

(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
0 340	Continued From page 10 replied via email requesting additional information. O/ULP-D and licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A, failed to acknowledge the request for additional information and failed to submit further information. The immediacy of correction order tag identification 1620 and 1390 was not lifted at the time of exit on November 9, 2022, at 3:10 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;	0 460		

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0 460	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 7, 2022, at 10:00 a.m., during the entrance conference, Licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A stated the facility did not have a call system in place for residents On November 7, 2022, at 10:15 a.m. LALD/ RN-A confirmed the licensee lacked a system for residents to request assistance for health and safety needs 24 hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 470	Continued From page 12 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (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 (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; (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: (i) awake; (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; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan as required and failed to post a staffing schedule. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 470		

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0 470	Continued From page 13 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 7, 2022, at 10:00 a.m., during entrance conference, housing manager, who was also unlicensed personal (HM/ULP)-B stated the facility was staffed twenty-four hours per day, seven days per week. During a facility tour on November 7, 2022, at 10:30 a.m., no staff schedule was observed to be posted in the facility. The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked - identify the direct-care staff member's resident assignments or work location - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On November 7, 2022 at 2:30 p.m., Licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A provided a staffing plan created in 2021. LALD/RN-A stated she was not aware of the requirement to develop and implement a staffing plan at least twice a year, and was not aware of determining staffing level based on residents' assessments and service plans.	0 470		

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0 470	Continued From page 14 The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured the facility could respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; - ensured one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: - awake; - 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; - capable of communicating with residents; - capable of providing or summoning the appropriate assistance; and - capable of following directions; No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 470		
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 15 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This 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 Novermber 8,2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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0 480	Continued From page 16 (21) days	0 480		
0 490 SS=I	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that created opportunities for active participation in the community at large. This had the potential to	0 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 490	Continued From page 17 affect all three residents of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's MnCHOICES Assessment Report dated August 12, 2022, identified R1 was at risk for wandering/elopement without supervision, damaged or destroyed property, break furniture and glasses if no immediate response, and further indicated R1 required 24 hour supervision to ensure his safety. The "Quality of Life" section included, "Activities the person enjoys doing" included, "Plays on keyboard; sings; goes for walks; enjoys going for car rides. He really likes playing with calculators and just got a tablet computer he likes." The report also identifeid R1 liked to go to the park. The report identified R1 required "consistent cues and reminders" throughout tasks. The form identified R1 was "disruptive of other's activities" and R1 "doesn't understand personal boundaries." R1 was admitted September 19, 2022, with diagnoses to include: severe autism, communication deficit, aggressive behavior, and mood swings. R1's Service Plan dated September 21, 2022, indicated R1 received medication administration, behavior management, dressing assistance, meal assistance, incontinence care and laundry.	0 490		

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0 490	Continued From page 18 R1's clinical record lacked evidence daily programs of social and recreational activities had been created or implement. R1's record included a progress note on October 10, 2022, written by unlicensed personal (ULP)-E, which identified, "The client [resident is] in his room, banging the walls, he broke two cups, he almost hit me want [sic] to bite me, he is making himself throw up and he ran outside [eloped] two time [sic] the staff had to bring him in the house." Also, R1's record included a progress note dated October 21, 2022, which identified, "The client gained weight in one month, gaining 10 lb [pounds] because he overeats; he does not know you are full Also he likes to have food with too much ranch [dressing] all the time." R1's Community Service Support Plan (CSSP) dated January 18,2022, indicated R1 did well when organized planned activities were provided. During the entrance conference on November 7, 2022, at 10:00 a.m., Licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A stated residents were involved in daily programs of social and recreational activities. During the facility tour on November 7, 2022, at 10:30 a.m., no evidence of recreation or daily programs of social activities, were observed in the facility. On November 8, 2022, at 10:00 a.m., R1 was observed to exit the building (elope) without staff and go back inside twice. At 11: a.m. R1 was observed to sit side-by-side with R3 on the sofa in the Livingroom, and then was observed pushing and hitting R3. Although staff intervened and	0 490		

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0 490	Continued From page 19 directed R1 to stop pushing and hitting, no social activity was offered to R1, such as to redirect from the observed behavior. On November 8, 2022 at 12:14 p.m., County Case Manager (CCM) stated R1 required 1:1 supervision and and verified the MnCHOICES Assessment form included specific information for R1's needs. For the duration of the survey from November 7, 2022, through November 9, 2022, no programs of social or recreational activities were observed to be provided to the facility residents. R1 and R3 were observed to be watching television (TV) most of the days. On November 9, 2022, at 11:26 a.m. (LALD/RN)-A stated no daily programs of social and recreational activities had been created or implemented for any of the residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as	0 570		

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0 570	Continued From page 20 required. 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 the residents). The findings include: During the facility tour on November 7, 2022, at 10:30 a.m. the surveyor did not observe a posting of the original current license at the facility's main entrance. On November 7, 2022, at 10:30 a.m. Licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A verified the license was not posted in the establishment's main entrance. RN/LALD-A stated she kept the license at the nurse office because "R1 was ripping papers and broke everything". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that	0 580		

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0 580	Continued From page 21 have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 7, 2022, at 10:00 a.m., during the entrance conference, licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A stated she discussed quality management topics with staff and stated the last meeting was on October 31, 2022. On November 7, 2022, at 11:07 a.m., the surveyor requested the licensee's documentation of any quality management activities, but no plan	0 580		

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0 580	Continued From page 22 was provided by the licensee. On November 9,2022, at 11:26 a.m. LALD/RN-A verified the license had no documentation of quality management activity. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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 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 observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse 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	0 630		

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0 630	Continued From page 23	0 630		

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 MnCHOICES Assessment Report dated August 12, 2022, identified R1 was at risk for wandering/elopement without supervision, damaged or destroyed property, break furniture and glasses if no immediate response, and further indicated R1 required 24 hour supervision to ensure his safety. The report also R1 required "consistent cues and reminders" throughout tasks. The form identified R1 was "disruptive of other's activities" and R1 "doesn't understand personal boundaries." The report identified R1 had a history of physical aggression towards others including: hitting, biting scratching and self-injurous behavior of "biting self." R1 was identified to break windows, glasses, lamps or furniture.The intervention section of the report identified R1 "needs redirection" and discribed the resident as needing constant supervision.

R1's diagnoses included, but were not limited to: severe autism, communication deficit, aggressive behavior, and mood swing. R1's Service Plan dated September 21, 2022, indicated R1 received medication administration, behavior management, assistance with dressing, meal assistance, incontinence care and laundry.

R1's IAPP dated October 7, 2022, indicated R1 "wandered" in and out of the facility building, was at risk for physical abuse, had difficulty communicating, may not report abuse or neglect

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	35546	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE CARE	3524 KYLE AVENUE NORTH CRYSTAL, MN 55422

(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
0 630	Continued From page 24 and was at risk of elopement from the facility. The IAPP lacked: -an individualized review or assessment of the resident'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. On November 7, 2022 at 10:30 a.m., during facility tour, R1's room was observed to have three holes on the wall. At the time of the observation, ULP-B stated R1 had also broken two televisions, ripped up papers, and had a behavior of throwing objects. On November 8, 2022, at 10:00 a.m., R1 was observed to exit the building (elope) without staff and go back inside twice. At 11: a.m. R1 was observed to sit side-by-side with R3 on the sofa in the Livingroom, and then was observed pushing and hitting R3. Staff were observed to intervene and directed R1 to stop pushing and hitting. On November 9, 2022, at 11:26 a.m. (LALD/RN)-A confirmed R1's IAPP lacked specific measures to be taken by staff to minimize risk of elopement, risk of abusing other residents, risk for destruction of property or self harm. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 680	Continued From page 25 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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 develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all three 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, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 26 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on November 7, 2022, at 10:30 a.m., no emergency exit diagrams were observed to be posted on each floor. On November 7, 2022, at 11:15 a.m. the surveyor requested to review the licensee's emergency preparedness plan (EP). The provided EP plan, policies and procedures lacked individualized emergency procedures to include the following content: - establish and maintain a comprehensive EP, reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - missing resident plan; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific	0 680		

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0 680	Continued From page 27	0 680		

roles in another's absence through succession planning and delegation of authority;
- a qualified person who was authorized, in writing, to act in the absence of the administrator;
- a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response;
- develop and implement EP policies/procedures and review/update annually;
- develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include:
    - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions;
    - alternate sources of energy to fire detection, extinguishing, alarms systems;
    - sewage and waste disposal;
- a tracking system used to document locations of residents, staff, and relocation of staff;
- develop policies and procedures to address safe evacuation from the facility including:
    - needs of evacuees;
    - staff responsibilities;
    - transportation;
    - evacuation location;
    - alternate communication means;
- develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility;
- develop policy and procedures to address:
    - systems of medical documentation that preserve resident information;
    - protects confidentiality;
    - secures/maintains availability of records;
- develop policy and procedures must address use of volunteers including process and role for integration;
- develop policy and procedures which address development and arrangements with other

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0 680	Continued From page 28 facilities or providers to receive residents in the event continuity of services cannot be provided; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; - volunteers; - communication plan must include contact information for: - Federal, State, tribal, regional, and local EP staff; - State Licensing and Certification Agency; - Minnesota (MN) Office of Ombudsman for long-term care (LTC); - other sources of assistance; - communication plan must include; - method for sharing information and medical documentation for residence; - means, in event of evacuation, to release resident information; - means of providing information about general condition and location of residents under [licensee's] care; - communication plan must include: - means to provide information about facility occupancy; - needs; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include A method for sharing information from emergency plan;	0 680		

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0 680	Continued From page 29 - must develop and maintain EP training and testing program, review/update annually; - training program must include initial EP training to policies and procedures to all new and existing staff and volunteers; - provide EP training at least annually; - maintain documentation of EP training; - demonstrate staff knowledge of EP; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. On November 09,2022. at 11:26 a.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, comfiremed the EP plan was missing required content. No further information provided TIME PERIOD FOR CORRECTION: Twenty-One (21)	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	0 780		

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0 780	Continued From page 30 (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 interconnected smoke detectors so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope(when problems are pervasive or present a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On November 7, 2022, from approximately 10:15 AM to 12:00 PM., survey staff toured the facility	0 780		

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0 780	Continued From page 31 with House Manager unlicensed personal (HM/ULP), Registered Nurse (RN)-A. During the facility tour, survey staff observed that the 1st floor hallway and bedrooms lacked interconnected smoke alarms. It was also observed that each level of the dwelling unit lacked interconnected smoke alarms. (HM/ULP)-B, (RN)-A verbally confirmed survey staff observations during the facility tour. 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 and interview the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors.	0 790		

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0 790	Continued From page 32 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 residents). The finding include: On November 7 2022, from approximately 10:15 AM to 12:00 PM, survey staff toured the facility with (HM/ULP)-B. During the facility tour, survey staff observed the facility's kitchen fire extinguishers were missing from extinguisher mount. (HM/ULP)-B verbally confirmed survey staff observation during the facility tour. No further information 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	0 800		

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0 800	Continued From page 33 by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope(when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On November 7, 2022, from approximately 10:15 AM. to 12:00 PM., survey staff toured the facility with (HM/ULP)-B, (RN)-A. During the facility tour, survey staff observed the following: 1. In basement behind dryer has accumulation of lint; 2. 1st floor hallway has 4"x 4" hole in wall next to thermostat, 3. 1st floor bedroom #2 has 5"x 5"hole in wall next to window, another hole next to bedframe 4"x4". 4. 1st floor hallway has 12' x 12" opening in ceiling covered with cardboard. (HM/ULP)-B, (RN)-A verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION:	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 800	Continued From page 34 Twenty-one(21) days	0 800		
0 810 SS=D	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced	0 810		

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0 810	Continued From page 35 by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all residents). The findings include: On November 7 2022, from approximately 10:15 AM to 12:00 PM, survey staff requested fire safety training and evacuation plan documentation, but the licensee could only provide one staff training and evacuation within the past year. (HM/ULP)-B, (RN)-A verbally confirmed survey staff observation during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 900		

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0 900	Continued From page 36 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 licensee failed to develop and execute a written and signed assisted living contract with the required content for one of one resident (R1).	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 900	Continued From page 37 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 was admitted September 19, 2022. R1' s Service Plan dated September 21, 2022, indicated R1 received medication administration, behavior management, dressing, meal assistance, incontinence care and laundry. R1's contract signed September 21, 2022, lacked resident information and designation of representative prior to the start of services. On November 9, 2022, at 11:26 a.m. (LALD/RN)-A provided a copy of R1's contract and stated it had not been signed by R1's case worker/guardian. The contract lacked resident information and designation of representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01390 SS=I	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff	01390		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE CARE	3524 KYLE AVENUE NORTH CRYSTAL, MN 55422

(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
01390	Continued From page 38	01390		

performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a registered nurse, who was also the licensed assisted living director (LALD/RN)-A) was readily available for consultation to the staff performing delegated nursing tasks and services. This had the potential to affect all residents and staff of the facility. The licensee hired LALD/RN-A to perform all nursing tasks. LALD/RN-A simultaneously held a nursing position working at a nursing home as needed on Tuesdays, Wednesdays, Saturday, and Sunday which would not allow them to be available 24 hours per day, 7 days per week, to address facility emergencies or concerns.

This resulted in an immediate correction order on November 09, 2022, at approximately 1:30 p.m.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

LALD/RN-A's Position Description-Registered Nurse signed October 10, 2019, indicated, "Registered Nurse is responsible for providing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35546	A. BUILDING: _____ B. WING _____	11/09/2022

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ATTENTIVE CARE	3524 KYLE AVENUE NORTH CRYSTAL, MN 55422

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01390	Continued From page 39 clinical services in home health care, provides supervisory visit according to nursing judgment and state home care licensure regulations." Although the "Job Responsibilities" included a list of 23 job responsibilities, including, but not limited to "appropriately updates assessment," the form did not refer to assisted living regulations appropriately and referenced "provides supervisory visits according to nursing judgement and state home care licensure regulation." The position description lacked procedural language which identified correct regulatory requirements and did not reflect how the facility would have registered nurse (RN) coverage for the assisted living. such as works full or part time, how the owner would ensure RN was providing appropriate clinical judgement to meet regulatory requirements. The form did not identify how LALD/RN-A would promote a safe environment. On November 7, 2022, at 10:00 a.m., during the entrance conference, housing manager who was also the unlicensed personal (HM/ULP)-B verified LALD/RN-A was the only employed nurse working at the facility. HM/ULP-B indicated LALD/RN-A worked at the assisted living facility (ALF) every Monday, Thursday, and Friday from 8:00 a.m., to 2:00 p.m., and remained on-call at all other times. On November 7, 2022, at 10:30 a.m., during the facility tour, the facility was noted to lack a schedule, including a schedule for RN coverage when services and delegated tasks were provided. On November 8, 2022, at approximately 4:30 p.m., an immediate order was written for tag identification number 1620, for lack of assessment.	01390		

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01390	Continued From page 40 On November 9, 2022 at 11:26 a.m., LALD/RN-A stated they held another nursing position as a "floor nurse" in a nursing home; LALD/RN-A stated they worked "as needed." LALD/ RN-A further stated they "will not answer phone calls" when providing direct care to residents at the nursing home. When asked if they would be able to leave the nursing home shift if an emergency occurred at the Assisted living Facility, LALD/ RN-A stated they would not be able to leave their nursing home shift. When asked if there was an emergency call requiring RN assessment at the assisted living facility, LALD/ RN-A stated she would not answer calls if providing direct care and stated staff "are trained to call 911 in case of emergency." LALD/ RN-A stated they worked at the assisted living facility about 18 hours per week. On November 9, 2022, at 12:30 p.m. owner, who was also the unlicensed personal (O/ULP)-D stated, "she is aware" a RN was required to be available while staff were performing delegated tasks and stated the facility needed "one more nurse." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On November 9, 2022, at 3:10 p.m., the immediacy of 1390 was not removed at the time of exit.	01390		
01620 SS=G	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	01620		

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01620	Continued From page 41	01620		

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.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to assess one of one resident (R1) for safety needs including, but not limited to the known history of elopement and risk for abuse to self and others.

This resulted in an immediate order issued on November 8, 2022, at approximately 4:30 p.m.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a

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01620	Continued From page 42 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 MnCHOICES Assessment Report dated August 12, 2022, identified R1 was at risk for wandering/elopement without supervision, damaged or destroyed property, break furniture and glasses if no immediate response, and further indicated R1 requires 24 hour supervision to ensure his safety. R1 was admitted September 19, 2022. R1's clinical record lacked evidence the LALD/RN assessed R1 prior to admission, including assessment for known safety concerns, such as, but not limited to, elopement from the facility and self-harm identified in the MnCHOICES Assessment Report . Although there was no evidence of an assessment on admission, R1' s Service Plan dated September 21, 2022, indicated R1 received medication administration, behavior management, assistance with dressing, meal assistance, incontinence care, and laundry. R1's Admission Assessment dated September 24, 2022, and 14 day assessment dated October 07, 2022, both completed by Licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A, indicated "resident is [at] risk for elopement/wandering, difficult to monitor, if he leaves the house never return [sic] to the home, he likes to escape the house," LALD/RN-A assessment did not address the one-to-one (1:1) supervision and required staffing plan to keep resident safe from elopement.	01620		

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01620	Continued From page 43 A progress note dated October 6, 2022, written by LALD/RN-A indicated "client [resident] was agitated, yelling at people, and jumping all over the house client was not stable, the nurse called 911 and transferred the client to the ER with [sic] unstable this morning." R1's record included a Master Care Plan dated October 7, 2022, which indicated, "Difficult to monitor the client [resident] related to mental impairment client go [sic] out with know [sic] the staff, It is difficult to put the workers in the back [of] house when a client elopes and leaves the house." A progress note dated October 10, 2022, written by unlicensed personal (ULP)-E indicated "the client in his room, banging the walls, he broke two cups, he almost hit me want to bite me, he is making himself throw up and he ran outside two time the staff had to bring him in the house." A progress note dated October 19, 2022, written by LALD/RN-A indicated "the caregiver doing 1:1 supervision redirected." On November 7, 2022, at 10:00 a.m., during the entrance conference, LALD/RN-A stated they had another job at another skilled nursing facility and was "on call" to the skilled nursing facility and stated she was scheduled at this Assisted living facility Monday, Thursday and Friday from 8:00 a.m. to 2:00 p.m. On November 7, 2022 at 10:30 a.m., during facility tour, R1's room was observed to have three holes on the wall. At the time of the observation, ULP-B stated R1 had also broken two televisions, ripped up papers, and had a	01620		

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01620	Continued From page 44	01620		

behavior of throwing objects. The facility lacked a posted schedule identifying which staff were working. ULP-B verified they were the only ULP working from 3:00 p.m. to 10:30 a.m., and leaving after working a double shift at 10:45 a.m. At approximately 10:00 a.m., ULP-C was observed to start work. ULP-C stated they had come in to help until 3:00 p.m. At 12:15 p.m., R1 was observed to be wandering in and out of the kitchen, and other facility rooms. ULP-C was observed to be the only staff scheduled to provide cares to all three residents. At 2:15 p.m., ULP-C was observed in the kitchen cooking, R1 was observed to enter another resident room, and LALD/RN-A intervened and redirected R1 to go their room.

On November 7, 2022 at 2:30 p.m., LALD/ RN-A stated R1 required 1:1 supervision. LALD/ RN-A stated one ULP was scheduled each shift, but if the ULP needed help, the owner, the nurse, or administrator would come to help for a "short time" and verified one ULP was expected to provide the care for all three residents, including cooking meals. LALD/RN-A verified there was no staff schedule and the last staffing plan was created in 2021.

On November 7, 2022 at 2:45 p.m.., owner, who was also the unlicensed personal (O/ULP)-D stated they knew R1 required staffing 1:1 supervision, and stated employees were quitting the job due to "resident's behavior, physical aggression" from R1 including: hitting, and biting; stating this lead to a shortage of employees. Also,(O/ULP)-D stated she hired two staff last month and was working on hiring more employees.

On November 08, 2022, at 8:30 a.m., ULP-B was

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01620	Continued From page 45	01620		

observed to administer medication to R1, and at 8:40 a.m. LALD/RN-A assisted R1 with shower. At 10:00 a.m. R1 was observed to exit the building (elope) without staff and go back inside twice. At 10:45 a.m. R1 was observed wandering in and out the building, no shoes, wearing shorts in winter, and LALD/RN-A intervened stated "it is cold outside", and R1 returned to the living room and staff closed the door. At 11: a.m., R1 was observed to sit side-by-side with R3 on the sofa in the living room, R1 was observed to then push and hit R3, and staff intervened and directed R1 to stop pushing and hitting.

On November 8, at 2022, at 10:30 a.m. a call and message was left for R1's guardian (No return call was received at the time of the immediate order).

On November 8, 2022 at 12:14 p.m., County Case Manager (CCM) stated R1 required 1:1 supervision. Also, CCM stated she discussed with the management the need to secure doors, and stated they (the facility) were working on an alarm for exit doors.

On November 8, 2022, at 1:30 p.m., LALD/RN-A stated "we are aware" R1 required 1:1 supervision, "but we are working on hiring more staff."

The license's policy dated March 14, 2020 indicated "Ongoing client [resident] monitoring and reassessment must be conducted as needed based on changes in the needs of the client".

On November 8, 2022, at approximately 4:30 p.m., an immediate order was issued for 1620.

TIME PERIOD FOR CORRECTION: Immediate

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01620	Continued From page 46 On November 09, 2022, at 3:10 p.m., the immediacy of 1620 was not removed at the time of exit.	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	01650		

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01650	Continued From page 47 Based on interview and record review, the licensee failed to ensure the service plan included the 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, 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 was admitted September 19, 2022. R1's clinical record lacked evidence the Licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A assessed R1 prior to implementing Service Plan, including assessment for known safety concerns, such as, but not limited to, elopement from the facility and self-harm identified in the MnCHOICES Assessment Report . Although, R1's Service Plan dated September 21, 2022, indicated the services and frequency of the services were based on the resident's most current assessment, there was no evidence of an assessment on admission. R1's Admission Assessment dated September 24, 2022, and 14 day assessment dated October 7, 2022, both completed by LALD/RN-A, indicated "resident is [at] risk for elopement/wandering, difficult to monitor, if he leaves the house never return [sic] to the home, he likes to escape the house," LALD/RN-A assessment did not address the one-to-one (1:1) supervision and required	01650		

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01650	Continued From page 48 staffing plan to keep resident safe from elopement. A progress note dated October 6, 2022, written by LALD/RN-A indicated "client [resident] was agitated, yelling at people, and jumping all over the house client was not stable, the nurse called 911 and transferred the client to the ER with unstable this morning.". After the incident no evidence R1's Service Plan was updated. A progress note dated October 19, 2022, written by LALD/RN-A indicated "the caregiver doing 1:1 supervision redirected," however, the record lacked evidence LALD/RN-A update the Service Plan after assessments on September 24, 22, and reassessment on October 7, 2022. On November 9, 2022, at 11:26 a.m. LALD/RN-A verified R1's Service Plan did not reflect the assessment completed September 24, 2022, or reassessment on October 7, 2022, and R1's Service Plan was not updated after changing of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

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

Type: Full
Date: *11/08/22*
Time: 09:30:59
Report: 1024221233

Food and Beverage Establishment Inspection Report

Location:
Attentive Care
3524 Kyle Avenue North
Crystal, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037671
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9527699221
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO ILLNESS LOG PRESENTED AT TIME OF INSPECTION. SENT COPY TO ADMINISTRATOR. PRINT, MAINTAIN AND FILL OUT ACCORDINGLY.

Comply By: 11/08/22

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.

THERMOMETER TEST STRIP LEFT ON SITE DID NOT REACH 160 dF. ADVISED TO REPAIR DISHWASHING MACHINE OR REPLACE AND ENSURE UTENSIL SURFACE TEMPERATURE REACHES 160 dF. DISCUSSED WASH, RINSE AND SANITIZING OPTIONS.

Comply By: 11/08/22

3-500C Microbial Control: date marking

3-501.17A ** Priority 2 **

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

OBSERVED OPENED PACKAGE OF SOFT CHEESE WITH NO DATE MARK. ITEM WAS MARKED ON SITE. DISCUSSED MARKING TCS FOODS WITH DATE IT IS OPENED AND ESTABLISHMENT CAN KEEP IT FOR AN ADDITIONAL 6 DAYS, 7 DAYS TOTAL WITH DAY 1 AS THE DAY ITEM IS OPENED.

Comply By: 11/08/22

4-300 Equipment Numbers and Capacities

4-302.12A ** Priority 2 **

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO THERMOMETER ON SITE TO MEASURE ANY FOOD TEMPERATURES. PROVIDE AND MAINTAIN.

Comply By: 11/08/22

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 THERMOMETER OR TEMPERATURE TEST STRIPS AVAILABLE ON SITE TO TEST UTENSIL SURFACE TEMPERATURE OF DISHWASHING MACHINE. PROVIDE AND MAINTAIN.

Comply By: 11/08/22

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

OBSERVED CARE TAKER WASH DISHES IN DESIGNATED HANDWASHING SINK IN KITCHEN. DISCUSSED MOVING HANDWASHING SINK TO LEFT SIDE IF RIGHT SIDE IS BEING USED FOR DISHES SINCE IT IS CLOSER TO THE DISHWASHING MACHINE.

Comply By: 11/08/22

6-300 Physical Facility Numbers and Capacities

6-301.11 ** Priority 2 **

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO HANDWASHING SOAP PROVIDED AT KITCHEN HANDWASHING SINK. PROVIDE AND MAINTAIN.

Comply By: 11/08/22

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO DISPOSABLE PAPER TOWELS OR HEATED AIR HAND DRYING DEVICE IN RESTROOM. PROVIDE AND MAINTAIN.

Comply By: 11/08/22

2-100 Supervision

2-102.12AMN

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

NO CFPM EMPLOYED. SENT FACT SHEET AND APPLICATION TO ADMINISTRATOR.

Comply By: 11/08/22

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

OBSERVED SIDE OF WOOD COUNTER LINING CRACKED AND EXPOSED. ADVISED TO REPAIR AND MAINTAIN.

Comply By: 12/08/22

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

OBSERVED FAILED SEAL ALONG COUNTER AND BACK SPLASH. ADVISED TO CAULK/SEAL TO AVOID WATER ENTRANCE.

Comply By: 11/08/22

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 SPILLED RICE AND NUTS ON CART IN KITCHEN BY TABLE. DISCUSSED CLEANING AND PEST CONTROL.

Comply By: 11/08/22

6-200 Physical Facility Design and Construction

6-201.11A

MN Rule 4626.1335A Design, construct, and install floors, floor coverings, walls, wall coverings, and ceilings to be smooth and easily cleanable.

OBSERVED 5 CRACKED AREAS IN FLOORING OF KITCHEN. COMPLY PER ABOVE RULE.

Comply By: 12/08/22

6-200 Physical Facility Design and Construction

6-202.15A

MN Rule 4626.1395A Seal holes, gaps, and other openings along floors, walls and ceilings to the outside of the building and provide self-closing, tight-fitting doors and windows for all outside openings.

OBSERVED SIGNIFICANT GAP ALONG DOOR IN KITCHEN. ADVISED TO COMPLY PER ABOVE RULE.

Comply By: 11/08/22

Surface and Equipment Sanitizers

Utensil Surface Temp: = at <150 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Holding/SHELLED EGG
Temperature: 36 Degrees Fahrenheit - Location: AMANA REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding/BEEF STEW
Temperature: 38 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	6	6

DISCUSSED THE FOLLOWING ON SITE WITH NURSING EVALUATOR, SAFIA HASSAN AND ADMINISTRATOR, ABDIHAKIM NURI:
- ALL ORDERS ON REPORT.
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- REPORTABLE DISEASES.
- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY.
- DATE MARKING AND DISCARD DATE.
- PROPER STACKING ORDER TO AVOID CROSS CONTAMINATION.
- PROPER TEMPERATURES FOR HOT AND COLD HOLDING, REHEATING, AND COOLING.
- DISCUSSED SAME DAY SERVICE AND IF RESIDENTS WANT TO KEEP FOODS FOR THEMSELVES, RESIDENT NAMES MUST BE ON THE FOOD.

- PROPER SANITIZING LEVELS.
- SUBMIT PLAN REVIEW THROUGH HRD AT MDH PRIOR TO ANY CONSTRUCTION OR REMODELING.
- PEST CONTROL: ESTABLISHMENT USES ROVE PEST CONTROL COMPANY.
- KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME-DAY SERVICE. OBSERVED INTACT POPCORN CEILING AND SMOOTH WALLS. ADVISED ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH TIME THESE ITEMS ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, ITEMS WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

- DISHWASHING MACHINE IS RESIDENTIAL AND HAS HI TEMP AND SANITIZE BUTTONS, HOWEVER IS NOT SANITIZING AT 160 dF.

IF ANY CUSTOMER COMPLAINS OF ILLNESS, ESTABLISHMENT IS REQUIRED TO NOTIFY THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER: 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 1024221233 of 11/08/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____

ABDIHAKIM NURIE
ADMINISTRATOR

Signed:_____

Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us