Electronically Delivered

February 21, 2025

Licensee
Universal Home Health of MN LLC
7040 Louisiana Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL37926016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 16, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

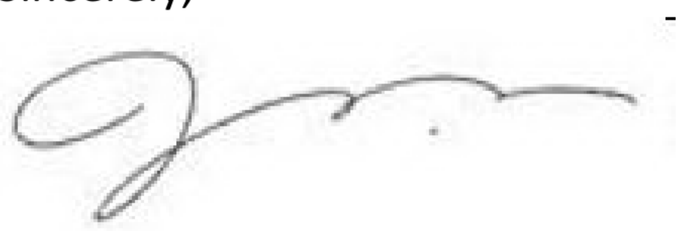
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37926	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HOME HEALTH OF MN LLC	7040 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55428

(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 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: SL37926016-0 On January 14, 2025, through January 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one resident receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On January 9, 2025, at 9:23 a.m., the BELTSS website indicated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C was the only LALD listed for the facility. LALD/CNS-C was licensed on June 4, 2021. On January 9, 2025, at 9:25 a.m., the BELTSS website indicated LALD/CNS-C was currently licensed as an assisted living director, but the director of record for the licensee had expired on October 31, 2023.	0 110		

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0 110	Continued From page 2 On January 14, 2025, at 10:21 a.m., LALD/CNS-C stated they thought they had renewed on the BELTSS website and stated they would follow up with BELTTS. On January 16, 2025, at 10:08 a.m., LALD/CNS-C stated they had updated the BELTSS website as the director of record and stated they initially misunderstood the need to be listed as the director of record for the licensee. The licensee's Assisted Living Director policy dated January 28, 2022, indicated the licensee expected the licensed or permitted director to comply with all requirements set by BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the	0 485		

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0 485	Continued From page 3 resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have menus prepared at least one week in advance and made available to all residents; failed to provide nutritious meals in accordance with United States Department of Agriculture (USDA) guidelines; failed to offer meal substitutions of similar nutritional value; and failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living monthly base fee for one of one resident. This had the potential to affect all residents. 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: On January 14, 2025, at 11:10 a.m., during a facility tour, the surveyor observed a seven-day menu posted in the kitchen that was dated October 13, 2024. The menu posted was not done seven days in advance; the menu did not offer meals according to the recommended dietary allowances in the USDA guideline "My Plate Guide;" and did not indicate any meal substitutions of similar value. R1 was admitted to licensee on November 12,	0 485		

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0 485	Continued From page 4 2022, with a diagnosis of dementia. R1's Resident Contract for Assisted Living dated December 9, 2022, indicated three (3) meals per day were included in the basic monthly fee. On January 16, 2025, at 10:18 a.m., finance manager/house manager (FM)-D stated the licensee did not charge for food and the resident had the option to eat three meals per day. FM-D stated the licensee discussed the menu with their resident and offered what the resident would like. The licensee's Food Service & Menu Planning policy dated January 28, 2022, indicated menus would be prepared at least one week in advance and made available to all residents; meals would be prepared according to the recommended dietary allowances in the USDA guidelines and meal substitutions would be of similar nutritional value. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660		

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0 660	Continued From page 5 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for two of two unlicensed personnel ((ULP)-A, ULP-B). 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: The licensee's Facility TB Risk Assessment dated June 14, 2024, identified the facility was at a low risk for TB transmission. ULP-A ULP-A was hired on December 1, 2024, as a Home Health Aide. ULP-A's Baseline TB Screening Tool for Health Care Personnel (HCPs) indicated a one-step	0 660		

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0 660	Continued From page 6 Mantoux was administered on November 26, 2024, and read on November 29, 2024. The one-step Mantoux lacked documentation of the time of administration and the time it was read as this needs to be read between 48 hours and 72 hours. Also, the one-step Mantoux lacked documentation of the induration and interpretation of the results. ULP-A did not have documentation of a second Mantoux as part of the two-step Mantoux as required for the Baseline TB Screening. ULP-B ULP-B was hired on September 7, 2023, as a Home Health Aide. ULP-B's record lacked a Baseline TB Screening Tool for Health Care Workers (HCWs). ULP-B's Serial TB Screening Tool for Health Care Workers (HSWs) dated October 23, 2023, indicated a one-step Mantoux was administered on October 23, 2023, at 8:00 a.m., and read on October 26, 2023, at 10:00 a.m. The one-step Mantoux was completed 49 days after the hire date. The results of the one-step Mantoux were read 74 hours after the administration of Tuberculin, which should be read between 48 hours and 72 hours. ULP-B did not have documentation of a second Mantoux as part of the two-step Mantoux as required for the Baseline TB Screening. On January 16, 2025, at 10:56 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they usually performed a two-step Mantoux unless it was not filed. LALD/CNS-C stated they had remembered doing a two-step Mantoux for ULP-B, but it may have been missed for ULP-A as they believed the	0 660		

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0 660	Continued From page 7 on-call nurse completed that Mantoux and used a different form. LALD/CNS-C stated they would have both employees redo the Baseline TB screening to make sure this would be compliant. The licensee's 8.16 Tuberculosis Screening policy dated January 28, 2022, indicated new staff whose essential job functions required work within the same air space of clients, would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs that included a two-step Mantoux. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680		

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0 680	Continued From page 8 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 observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z; and failed to post the EPP prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 14, 2025, at 11:10 a.m., during a tour of the facility, the surveyor observed a single page document posted in a prominent area that contained brief descriptions of what to do in selected emergencies. The posting failed to identify where to locate the full EPP with all the required content. The licensee's Hazard Vulnerability Analysis was last prepared and reviewed on December 17, 2022. The licensee lacked documentation of annual review and/or updates of their EPP.	0 680		

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0 680	Continued From page 9 The licensee's undated EPP lacked evidence of arrangements with other facilities. On January 14, 2025, at 11:22 a.m., financial manager/house manager (FM)-D stated they had taken the EPP in the office for updates. On January 16, 2025, at 1:44 p.m., FM-D stated the license had a verbal agreement with another assisted living facility and thought that agreement was documented in an email, however they did not have a contract with the EPP binder. FM-D stated they would try to retrieve the agreement and place it in the EPP binder. The licensee's Emergency Preparedness policy dated January 28, 2022, indicated the licensee would have in place an EPP that is in alignment with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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.	0 800		

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0 800	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 15, 2024, at approximately 11:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. The following was observed. GENERAL MAINTENANCE: The main level bathroom had a large amount of water staining in the ceiling skylight area. The staining appeared to be a leak from the skylight. LALD/CNS-C stated they would repair the skylight if it was leaking. The deck had broken decking boards. Broken decking boards have the potential to cause injury. The ceiling in the basement office was damaged and heavily stained. LALD/CNS-C stated they had	0 800		

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0 800	Continued From page 11 a leak above the ceiling in the past that was repaired, but the ceiling had not been repaired. On January 15, 2024, LALD/CNS-C stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HOME HEALTH OF MN LLC	7040 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55428

(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
0 810	Continued From page 12 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 15, 2024, at approximately 12:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building	0 810		

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0 810	Continued From page 13 layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with fire alarms. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have a fire alarm system. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On January 15, 2024, LALD/CNS-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	01370		

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01370	Continued From page 14 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	01370		

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01370	Continued From page 15 Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on December 1, 2024, as a Home Health Aide. On January 14, 2025, at 8:14 a.m., the surveyor observed ULP-A assisting R1 with medication administration. ULP-A's personnel record lacked evidence of completed training and/or competency testing for the following: - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - procedure to utilize in handling various emergency situations, and	01370		

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01370	Continued From page 16 - awareness of commonly used health technology equipment and assistive devices. ULP-B ULP-B was hired on September 7, 2023, as a Home Health Aide. ULP-B's personnel record lacked evidence of completed competency testing for the following: - care of teeth, gums, and oral prosthetic devices; and - care and use of hearing aids. On January 16, 2025, at 10:44 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were not aware of the specific training/competency training required. LALD/CNS-C stated the direction was not clear in Statue and felt this was a language barrier as it was not detailed enough. LALD/CNS-C stated they were going to discuss with a consulting company for assisted living facilities. LALD/CNS-C stated they understood the Statue better after discussion with the surveyor and they would work on making their training better. The licensee's 5.02 Competency Training Evaluations policy dated January 28, 2022, indicated training and competency evaluations for all unlicensed personnel would include the required topics and ULP's would not work until they had successfully passed the written and demonstrated competency evaluation. The policy listed all the required training and competencies topics needed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	01470		

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01470	Continued From page 18 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an orientation which included all required content for one of two unlicensed personnel ((ULP)-A). 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: ULP-A was hired on December 1, 2024, as a	01470		

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01470	Continued From page 19 Home Health Aide. On January 14, 2025, at 8:14 a.m., the surveyor observed ULP-A assisting R1 with medication administration. ULP-A's personnel record lacked evidence of orientation training that included an overview of assisted living statues; handling emergencies and using emergency services; reporting maltreatment of vulnerable adults or minors; handling of resident complaints, reporting of complaints, where to report; consumer advocacy services; and review of types of assisted living services the employee would provide and provider's scope of license. On January 16, 2025, at 11:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they would make sure the orientation training for ULP-A got completed before the weekend. LALD/CNS-C stated the licensee would have all staff complete the required orientation training prior to providing any cares going forward. On January 16, 2025, at 11:05 a.m., financial manager/house manager (FM)-D stated they had discussed the orientation with ULP-A, and they were usually in the facility to oversee any questions ULP-A would have during their shift. The licensee's Orientation of Staff and Supervisors & Content policy dated January 28, 2022, indicated all employees would complete an orientation before providing services to residents and it would include an overview of assisted living statues; handling emergencies and using emergency services; reporting maltreatment of vulnerable adults or minors; handling of resident	01470		

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01470	Continued From page 20 complaints, reporting of complaints, where to report; consumer advocacy services; and review of types of assisted living services the employee would provide and provider's scope of license. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500		

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01500	Continued From page 21 (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each twelve months of employment for one of one unlicensed personnel ((ULP)-B). 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	01500		

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01500	Continued From page 22 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: ULP-B was hired on September 7, 2023, as a Home Health Aide. ULP-B's personnel record lacked evidence of annual training for assisted living bill or rights, infection control techniques, and effective approaches to use to problem solve when working with a resident's challenging behaviors. On January 15, 2025, at 10:25 a.m., financial manager/house manager (FM)-D stated the licensee had a process for annual training and they were aware of the required annual training. FM-D stated they talk with staff about the need to complete their annual training after they had assigned the courses in a web-based training program. FM-D stated they were disappointed in themselves that the annual training was missed for ULP-B as they thought they had a good system in place by putting reminders on their calendar to follow up. On January 16, 2025, at 11:18 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they forgot to assign the annual trainings, and this was an oversight. LALD/CNS-C stated they would assign the annual trainings still needed. The licensee's 5.06 Annual Required Staff Training policy dated January 28, 2022, indicated	01500		

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01500	Continued From page 23 all staff who provided direct care would complete eight hours of annual training for each twelve months of employment and the annual training would include the training elements as required by statue. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for	01530		

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01530	Continued From page 24 each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received two (2) hours of annual dementia care training for direct care employees as required for one of one unlicensed personnel ((ULP)-B). 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: ULP-B was hired on September 7, 2023, as a Home Health Aide. ULP-B's personnel record lacked two (2) hours of annual dementia care training in 2024. On January 16, 2025, at 11:18 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they forgot to assign the annual trainings, and this was an oversight. LALD/CNS-C stated they would assign the annual trainings still needed. The licensee's Dementia Training policy dated January 28, 2022, indicated direct care employees would complete at least two (2) hours of education on topics related to dementia for each twelve (12) months of employment	01530		

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01530	Continued From page 25 thereafter. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37926	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HOME HEALTH OF MN LLC	7040 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55428

(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
01790	Continued From page 26 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented training and competencies for two of two unlicensed personnel ((ULP)-A, ULP-B) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available.	01790		

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01790	Continued From page 27 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A On January 14, 2025, at 8:14 a.m., the surveyor observed ULP-A assisting R1 with medication administration. ULP-A was hired on December 1, 2024, as a Home Health Aide. ULP-A's personnel record lacked documentation ULP-A was trained and found competent at this facility to provide medications to residents who had unplanned times away. ULP-B ULP-B was hired on September 7, 2023, as a Home Health Aide. ULP-B's personnel record lacked documentation ULP-B was trained and found competent at this facility to provide medications to residents who had unplanned times away. On January 16, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated it was an oversight in the Statue and they were not aware of the competency needed.	01790		

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01790	Continued From page 28 The licensee's Medication Management - Planned & Unplanned Time Away policy dated January 28, 2022, indicated unlicensed personnel would be trained and deemed competent by a registered nurse prior to performing the task. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with bed rails. 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:	02310		

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	37926	A. BUILDING: _____ B. WING _____	01/16/2025

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02310	Continued From page 29 On January 14, 2025, at 11:10 a.m., during a facility tour with financial manager/house manager (FM)-D, the surveyor observed R1 had a hospital style bed with bilateral upper side rails. The side rails were grabbed by the surveyor and noted the left-side rail was loose and the right-side rail was secured when looking at the bed from the foot of the bed. On January 15, 2025, at 8:14 a.m., the surveyor observed R1 independently transferring out of bed without using the side rail or an assistive device. R1 was admitted to licensee on November 12, 2022, with a diagnosis of dementia. R1's Service Plan dated September 7, 2024, indicated R1 received the following services: appointment reminder, bathing reminder, assist with dressing and grooming, housekeeping, laundry, light therapy, behavior management, meal reminder and assistance, medication administration, medication setup, pain monitoring, safety check, shopping assistance, socialization, toileting, and transportation assistance. R1's Side-Rail Use Assessment Form dated October 24, 2024, and December 22, 2024, lacked documentation of measurements of zones of entrapment. On January 16, 2025, at 10:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had completed a side rail assessment and looked at the entrapment spaces. LALD/CNS-C stated they did measure all the required zones but assumed the documentation of the zones meeting the guidelines were sufficient and did not document	02310		

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	37926	A. BUILDING: _____ B. WING _____	01/16/2025

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UNIVERSAL HOME HEALTH OF MN LLC	7040 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55428

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02310	Continued From page 30 the specific measurements for each zone. LALD/CNS-D stated they currently taught different facilities on side rails and had recently attended a discussion with a consultant company for assisted living facilities on side rails. LALD/CNS-C stated they were not notified of the loose side rail and would have this tightened up today. LALD/CNS-C stated they would add to R1's care plan for the staff to check the side rails daily and to notify the nurse when these are loose. The licensee's Side Rails policy dated January 28, 2022, indicated licensee would assess the use of side rails, educate the resident and/or responsible person regarding the risks and benefits of side rails, verify the side rail in use was of safe design, and utilized consistent with the manufacturer's directions. The policy also indicated the side rail design would be consistent with FDA's 2006 recommended dimensional measurements to reduce entrapment. The FDA's A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone.	02310		

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02310	Continued From page 31 The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQs) website read under hospital-style bed rails licensees should ensure, "measurements were completed and documented, the rails were FDA compliant, and the risk versus benefits were discussed and documented with the resident/responsible party." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *01/14/25*
Time: 12:49:13
Report: 1021251009

Food and Beverage Establishment Inspection Report

Location:
Universal Home Health of MN
7040 Louisiana Ave N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0041139
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: KITCHEN SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temperature
Temperature: 37 Degrees Fahrenheit - Location: FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: YOGURT - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH FINANCE MANAGER/CFPM, JUDITH ONSOMU AND HEALTH REGULATION DIVISION NURSE EVALUATOR, RHAWNIE QUINEHAN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 1 CLIENT AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH STAFF, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

Food and Beverage Establishment Inspection Report

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, PAINTED DRYWALL, VINYL FLOORS, LAMINATE COUNTERTOPS AND TEXTURED CEILING. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

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 1021251009 of 01/14/25.

Certified Food Protection Manager: JUDITH N. ONSOMU

Certification Number: FM108721 Expires: 12/01/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

JUDITH NYABOKE ONSOMU
FINANCE MANAGER/CFPM

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us