Electronically Delivered

April 16, 2025

Licensee
Wabe Home Residential Services
5177 Red Oak Drive
Arden Hills, MN 55112

RE: Project Number(s) SL40397015

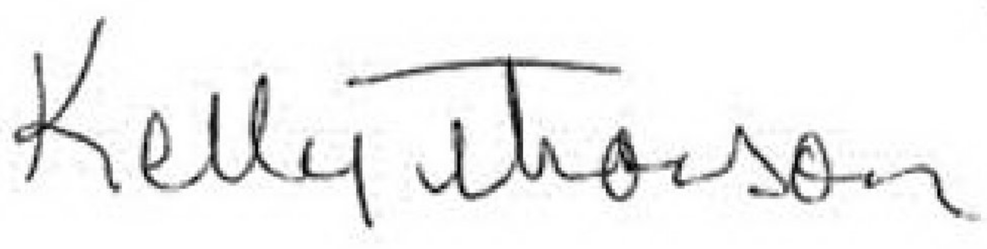
Dear Licensee:

On March 19, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 9, 2025. This follow-up survey verified that the facility is n substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

February 27, 2025

Licensee
Wabe Home Residential Services
5177 Red Oak Drive
Arden Hills, MN 55112

RE: Project Number(s) SL40397015

Dear Licensee:

Please note: This letter amends the previous letter dated February 19, 2025. Specifically, the first paragraph now includes information concerning the granting of your assisted living facility license. The second paragraph correctly refers to the survey conducted on January 9, 2025, as an initial survey. No other changes have been made.

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on January 9, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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
Per 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 residents/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.

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
	40397	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABE HOME RESIDENTIAL SERVICES	5177 RED OAK DRIVE ARDEN HILLS, MN 55112

(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: SL40397015-0 On January 6, 2025, through January 9, 2025, the Minnesota Department of Health conducted a survey at the above provider. At the time of the survey, there were two residents receiving services under the provisional Assisted Living Facility license. On January 7, 2025, an immediate correction order was issued for tag identification number 1290. During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 6, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the licensee's grievance procedure along with the required contact information. This had the potential to affect all the licensee's current 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 potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 4 The findings include: On January 6, 2025, at 12:05 p.m., during a tour of the facility, the surveyor did not observe a posting of the licensee's grievance procedure. On January 6, 2025, at 1:35 p.m., clinical nurse supervisor (CNS)-D stated they thought posting the reporting of vulnerable adult process would meet the statue requirement and stated the statue was not clear to them that they needed to post the grievance procedure. The licensee's Grievance policy dated August 1, 2021, indicated the grievance procedure would be conspicuously posted in the facility with the following contact information: name, phone number and email contact for the individuals who were responsible for handling resident complaints; Offices of Ombudsman for Long-Term Care (OOLTC), Mental Health and Developmental Disabilities (OOMHDD), and Minnesota Adult Abuse Reporting Center (MAARC). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630		

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0 630	Continued From page 5 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) was developed to include the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: R2 was admitted to licensee on October 17, 2024, with diagnosis of chronic obstructive pulmonary disease (COPD). R2's Service Plan dated October 25, 2024, indicated R2 received assistance with bathing, ambulation, dressing, meals, and medication administration. R2's IAPP completed on November 18, 2024, lacked assessment of the person's risk of abusing other vulnerable adults.	0 630		

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0 630	Continued From page 6 On January 7, 2025, at 2:36 p.m., the surveyor observed clinical nurse supervisor (CNS)-D reviewing R2's assessment on their laptop and had showed the surveyor where they did not address the risk to abuse other vulnerable adults on their assessment. The surveyor observed the licensee's assessment had options for the nurse to check to indicate if the resident was at risk for abusing other vulnerable adults or not at risk of abusing other vulnerable adults, however both options were left blank. The surveyor then observed CNS-D looking up the statue and stated "yep, it is there, I was not aware of this." CNS-D then stated they believed [R2] was not at risk to abuse other vulnerable adults and if they had thought [R2] was at risk to abuse other vulnerable adults, then they would have added that to [R2]'s IAPP. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated an IAPP would be established for each vulnerable adult for whom assisted living services were provided and the plan would include the resident's risk of abusing other vulnerable adults. 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 (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	0 680		

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0 680	Continued From page 7 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. 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:	0 680		

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0 680	Continued From page 8 The licensee's undated EP plan lacked evidence of the following required content: - maintain and annual EP updates; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a wavier declared by secretary; - names and contact information; - methods for sharing information; and - long term care (LTC) family notifications. On January 9, 2025, at 2:27 p.m., clinical nurse supervisor (CNS)-D stated all emergency information should have been in the EP binder. CNS-D stated the EP plan should have met all the requirements and the licensee would correct the EP plan going forward. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have a plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. The policy referenced CMS State Operations Manual Appendix Z and MN Rules 4659.0100. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for	0 780		

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0 780	Continued From page 9 sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 780		

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0 780	Continued From page 10 On a facility tour on January 8, 2025, from 2:00 p.m. to 3:00 p.m., with clinical nurse supervisor (CNS)-D, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: SMOKE ALARMS There was not a smoke alarms located outside in the immediate vicinity of resident sleeping room four. Smoke alarms are required outside in the immediate vicinity of all sleeping rooms. The smoke alarms were tested by CNS-D, and the surveyor observed the smoke alarm inside resident sleeping room four was not interconnected so activation of the smoke alarm activates all alarms throughout the facility. EMERGENCY ESCAPE AND RESCUE OPENINGS The window well covers in resident sleeping rooms four and five in the basement were positioned so the window contacts the outside cover when opening. Emergency escape and rescue openings are required to be readily openable from the inside without obstructions. FURNACE ROOM COMBUSTION AIR The surveyor observed the furnace/ water heater room was very warm and the exterior combustion air duct providing fresh air to the furnace/ boiler room was plugged and not allowing fresh air as required into the space. Fresh exterior combustion air is required to be provided in rooms containing gas burning appliances according to MSFC in Minnesota Rules Chapter	0 780		

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0 780	Continued From page 11 7511 and the Minnesota Mechanical and Fuel Gas Code in Minnesota Rules Chapter 1346. EXTENSION CORDS There was an extension cord used as permanent wiring for the clothes washing machine. Clothes washing machines are required to be plugged directly into an electrical outlet or powered by an approved power strip with over current protection. During the facility tour CNS-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780		
0 790 SS=C	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 maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents.	0 790		

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	40397	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABE HOME RESIDENTIAL SERVICES	5177 RED OAK DRIVE ARDEN HILLS, MN 55112

(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
0 790	Continued From page 12 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On a facility tour on January 8, 2025, from 2:00 p.m. to 3:00 p.m., with clinical nurse supervisor (CNS)-D, it was observed that the extra fire extinguishers in the basement had a manufacture date of 2022 and had not been serviced annually as required. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During the facility tour CNS-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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0 800	Continued From page 13	0 800		
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's 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 affect a limited number of 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 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). Findings include: On a facility tour on January 8, 2025, from 2:00 p.m. to 3:00 p.m., with clinical nurse supervisor (CNS)-D, the surveyor made the following observations of facility disrepair: The window handle on the non-emergency	0 800		

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0 800	Continued From page 14 escape and rescue window in resident sleeping room one was broken and would not open the window. During the facility tour CNS-D, verified the above listed observations while accompanying on the tour. 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.	0 810		

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0 810	Continued From page 15 (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training. 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 8, 2025, at 3:00 p.m., clinical nurse supervisor (CNS)-D, 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 provided FSEP, failed to include the following: The available FSEP included employee	0 810		

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0 810	Continued From page 16 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 layout and environmental risks. The plan failed to include employee procedures accurate to this specific building and referenced a large commercial facility. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on January 8, 2025, at 3:15 p.m., CNS-D, stated the FSEP employee actions were not accurate to this facility, and resident actions and unique needs for evacuation were not provided in the FSEP. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation the employee training was provided separate from evacuation drills as required.	0 810		

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0 810	Continued From page 17 Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the residents were provided training as required. During an interview on January 8, 2025, at 3:30 p.m., CNS-D, stated the above requested training documentation was not available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the	0 900		

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0 900	Continued From page 18 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 observation, interview, and record review, the licensee failed to execute a written contract with the required content prior to provided housing and assisted living services for two of two residents (R2, R3); and failed to provide the licensee's complete unsigned assisted living contract to the Office of Ombudsman for Long-Term Care (OOLTC). This had the potential to affect all residents and prospective 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 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 December 31, 2024, at 11:12 a.m., an email from the OOLTC representative indicated licensee had not provided a blank unsigned assisted living contract to the OOLTC as required. R2 R2 was admitted to licensee on October 17,	0 900		

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0 900	Continued From page 19 2024, with a diagnosis of chronic obstructive pulmonary disease (COPD). R2's Service Plan dated October 25, 2024, indicated R2 received assistance with bathing, ambulation, dressing, meals, and medication administration. R2's undated Assisted Living Contract was signed on October 25, 2024. The contract was signed after R2 had been provided housing and assisted living services. R3 R3 was admitted to licensee on October 1, 2024, with a diagnosis of disorganized schizophrenia (schizophrenia characterized by disorganized thinking, speech, and behaviors). R3's record lacked a signed service plan. On January 7, 2025, at 9:17 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R3 with medication administration. R3's undated Assisted Living Contract was signed on October 28, 2024. The contract was signed after R3 had been provided housing and assisted living services. On January 7, 2025, at 2:22 p.m., clinical nurse supervisor (CNS)-D stated R2's contract was the only contract the licensee had signed by R2 and stated it took R2 some time to get acclimated to the facility. CNS-D stated they try to make sure everything is completed timely, but it was not always possible. CNS-D they had to coordinate with R3's guardian after R3 moved in to get the contract signed.	0 900		

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0 900	Continued From page 20 On January 8, 2025, at 11:53 a.m., CNS-D stated they were not aware they needed to provide the OOLTC with the licensee's unsigned assisted living contract and stated they would provide this to the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding	0 950		

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0 950	Continued From page 21 subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language notice for one of two residents (R2); and failed to offer the resident the opportunity to identify a designated representative in writing for two of two residents (R2, R3). 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: R2 R2 was admitted to licensee on October 17, 2024, with a diagnosis of chronic obstructive pulmonary disease (COPD). R2's undated Assisted Living Contract signed on October 25, 2024, lacked the verbatim designation of representative statutory language notice and a section for the resident to designate a representative or decline to name a representative. R3	0 950		

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0 950	Continued From page 22 R3 was admitted to licensee on October 1, 2024, with a diagnosis of disorganized schizophrenia (schizophrenia characterized by disorganized thinking, speech, and behaviors). R3's undated Assisted Living Contract signed on October 28, 2024, had the verbatim designation of representative statutory language notice and a section for the resident to designate a representative or decline to name a representative, however this section was blank. On January 8, 2025, at 12:14 p.m., clinical nurse supervisor (CNS)-D stated they were not aware of the designation of representative statutory language and the requirement to have residents initial if this was declined. CNS-D stated they would make sure the residents received this notice upon contract signing going forward. Also, CNS-D stated R3 had a guardian that did not complete this section when they had signed the contract, and the licensee did not follow up since it was the guardian of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains,	01060		

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01060	Continued From page 23 at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to	01060		

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01060	Continued From page 24 the resident, legal representative, and designated representative for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: R2 was admitted to licensee on October 17, 2024, with a diagnosis of chronic obstructive pulmonary disease (COPD). R2's Service Plan dated October 25, 2024, indicated R2 received assistance with bathing, ambulation, dressing, meals, and medication administration. R2's Resident Notes dated December 26, 2024, at 11:19 a.m., indicated R2 was sent to hospital by ambulance due to chest pain. R2's record lacked documentation of the return date from the hospital. R2's record lacked documentation R1, R1's legal representative, and R1's designated representative received a written notice with all the required content for an emergency relocation. On January 7, 2025, at 2:56 p.m., clinical nurse supervisor (CNS)-D asked surveyor, "Notice? What do you mean?" and then stated the resident was not provided a written notice as RN-A was not aware of this statue. The surveyor observed CNS-D reviewing the statue and stated the	01060		

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01060	Continued From page 25 language was very vague and open for interpretation. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated the licensee would as soon as possible provide written notice of emergency relocation to the resident, the resident's legal representative, the resident's designated representative, and the resident's case manager if they received home and community-based services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40397	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABE HOME RESIDENTIAL SERVICES	5177 RED OAK DRIVE ARDEN HILLS, MN 55112

(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
01290	Continued From page 26 Based on interview and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for one of seven employees (unlicensed personnel (ULP)-E). 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: The licensee's undated Employee List included ULP-E was a current employee. On January 6, 2024, at 10:21 a.m., the surveyor confirmed with clinical nurse supervisor (CNS)-D, the undated Employee List was current and had all active employees that worked at the facility for the licensee. ULP-E was hired on July 1, 2024. ULP-E's employee record lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents. The licensee's October 2024 schedule indicated ULP-E was scheduled to work every day in the month of October except for Saturdays on the following dates: October 5, 2024, October 12, 2024, October 19, 2024, and October 26, 2024.	01290	During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	Continued From page 27 The licensee's November 2024 schedule indicated ULP-E was scheduled to work every day in the month of November except for Saturdays on the following dates: November 2, 2024, November 9, 2024, November 16, 2024, November 23, 2024, and November 30, 2024. The licensee's December 2024 schedule indicated ULP-E was scheduled to work every day in the month of December except for Saturdays on the following dates: December 7, 2024, December 14, 2024, December 21, 2024, and December 28, 2024. The licensee's January 2025 schedule indicated ULP-E was not scheduled to work January 1, 2025, through January 7, 2025, and then resumed their schedule of working every day except Saturdays as followed: January 11, 2025, January 18, 2025, and January 25, 2025. A review of the NETStudy 2.0 website on January 7, 2025, at 1:07 p.m., indicated ULP-E's background study application was closed by NETStudy on May 3, 2024, but no notice was sent to the licensee. On January 6, 2024, at 1:19 p.m., clinical nurse supervisor (CNS)-D stated ULP-E had provided resident care without supervision. On January 6, 2024, at 3:08 p.m., the surveyor observed CNS-D on the phone. CNS-D stated they had licensed assisted living director (LALD)-C on the phone. LALD-C introduced themselves to the surveyor and stated they called the Department of Human Services (DHS) regarding the background study for ULP-E. LALD-C stated DHS informed them, DHS had sent an email to ULP-E to request a signature	01290		

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01290	Continued From page 28 from ULP-E to give consent for DHS to release the background study to the licensee, however DHS had never received the consent from ULP-E and had to close the background study for ULP-E. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated licensee would complete a Minnesota Department of Human Services (DHS) background study on all employees following the step-by-step procedure established by DHS. The licensee's Personnel Records policy dated August 1, 2021, indicated results of a background study would be kept in the personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01470 SS=F	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;	01470		

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01470	Continued From page 29 (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 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.	01470		

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01470	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services 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) 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: ULP-A ULP-A was hired July 1, 2024. On January 7, 2025, at 9:17 a.m., the surveyor observed ULP-A assist R3 with medication administration. ULP-A's Orientation Checklist and Requirements dated April 25,2024, indicated orientation for 144A Statues was completed, but not 144G Statues. ULP-A's personnel record lacked evidence of orientation training that included an overview of assisted living statues; 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	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 31 would provide and provider's scope of license. ULP-B ULP-B was hired July 1, 2024. On January 8, 2025, at 3:00 p.m., the surveyor observed ULP-B provide activity with R2 and R3 at the dining table in the kitchen. ULP-B's Orientation Checklist and Requirements dated April 25,2024, indicated orientation for 144A Statues was completed, but not 144G Statues. ULP-B's personnel record lacked evidence of orientation training that included an overview of assisted living statues; 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 7, 2025, at 11:38 a.m., clinical nurse supervisor (CNS)-D stated they had called a consultant organization and was told the licensee would be compliant with the Statue if they followed the Orientation Checklist. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all employees would complete an orientation before providing services and it would include an overview of assisted living statues; 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.	01470		

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01470	Continued From page 32 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required dementia care training was completed within 160 working hours of the employment start date 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) 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: ULP-A ULP-A was hired July 1, 2024. On January 7, 2025, at 9:17 a.m., the surveyor observed ULP-A assist R3 with medication administration.	01490		

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01490	Continued From page 33 ULP-A's records lacked evidence of at least eight hours of initial dementia training within 160 working hours respectively of the employment start date to include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. ULP-B ULP-B was hired July 1, 2024. On January 8, 2025, at 3:00 p.m., the surveyor observed ULP-B provide activity with R2 and R3 at the dining table in the kitchen. ULP-B's records lacked evidence of at least eight hours of initial dementia training within 160 working hours respectively of the employment start date to include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. On January 8, 2025, at 10:39 a.m., clinical nurse supervisor (CNS)-D stated the licensee did not complete any dementia training as this was overlooked. CNS-D stated the licensee did not offer dementia services at the facility and felt this was not fair as they did not provide that service and did not have an assisted living dementia care license.	01490		

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01490	Continued From page 34 On January 8, 2025, at 11:43 a.m., CNS-D stated both ULP-A and ULP-B have worked well over 160 hours since July. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees would need to complete at least eight hours of initial education within 160 hours of employment start date in the following required topics: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 35 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 interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 14 calendar days from the initiation of services for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: R2 was admitted to licensee on October 17, 2024, with a diagnosis of chronic obstructive pulmonary disease (COPD). R2's Service Plan dated October 25, 2024, indicated R2 received assistance with bathing, ambulation, dressing, meals, and medication administration.	01620		

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01620	Continued From page 36 R2's record included an initial assessment on October 17, 2024, and a 14-day assessment completed on November 2, 2024. The 14-day assessment had been completed 16 days after the resident moved into the facility. On January 9, 2025, at 2:31 p.m., clinical nurse supervisor (CNS)-D stated they could see the assessment was due on the 31st and stated they are generally available for the licensee's assessments and try to have these done prior to the due date. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the RN would provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 37 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee to document agreement on the services to be provided for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R3 was admitted to licensee on October 1, 2024, with a diagnosis of disorganized schizophrenia (schizophrenia characterized by disorganized thinking, speech, and behaviors). On January 7, 2025, at 9:17 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R3	01640		

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01640	Continued From page 38 with medication administration. R3's record lacked a service plan with a signature from a representative of the licensee and the resident or resident's representative with all current services provide by licensee. On January 9, 2025, at 1:09 p.m., an email sent by the licensee indicated they were not able to locate a signed service plan for R3 and indicated the service plan was given to R3's guardian to sign along with other documents, however this document was never signed. The license indicated in the email, they did not know why, and they would communicate with R3's guardian to sign the service plan as soon as possible. The licensee's Service Plan policy dated August 1, 2021, indicated the initial service plan and any revisions would be signed by a representative from the licensee and the resident or resident's representative to indicate an agreement of the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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

Type: Full
Date: *01/06/25*
Time: 23:30:00
Report: 1025251001

Food and Beverage Establishment Inspection Report

Location:
WABE HOME RESIDENTIAL SERVICES
5177 RED OAK DRIVE
Mounds View, MN55112
Ramsey County, 62

Establishment Info:
ID #: N5177RE
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

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.

The following orders were issued during this inspection.

4-200 Equipment Design and Construction

4-201.11

MN Rule 4626.0505 Replace equipment or utensils that are not durable or do not retain their characteristic qualities under normal use conditions.

Discontinue the use of and replace cooking utensils with a damaged, pitted, or scratched non-stick finish, replace if necessary.

Comply By: 01/17/25

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

WABE HOME RESIDENTIAL SERVICES
5177 RED OAK DRIVE MOUNDS VIEW MN 55112

FACILITY
Appliances are residential
Food TMD and waterproof min/max TMD available

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher with a sanitize cycle

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces.

DISHWASHING - NSF 184
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) - use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
In case of emergency or service interruption, have an alternate means of chemical sanitizing available (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)

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

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

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

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

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

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

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

Type: Full
Date: *01/06/25*
Time: 23:30:00
Report: 1025251001

Food and Beverage Establishment Inspection Report

WABE HOME RESIDENTIAL SERVICES

https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

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 1025251001 of 01/06/25.

Certified Food Protection Manager Fozia Abdi

Certification Number: FM121487 Expires: 01/31/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Casey Kipping
Public Health Sanitarian III
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