DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

January 25, 2022

Administrator
Midwest Residential, Inc.
5620 West 99th Street
Bloomington, MN 55437

RE: Project Number(s) SL36953015-1

Dear Administrator:

On December 20, 2021, the Minnesota Department of Health completed a follow-up evaluation of your agency to determine if orders from the October 22, 2021, evaluation were corrected. The follow-up evaluation verified that the agency is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

pmb

Electronically Delivered

November 21, 2021

Administrator
Midwest Residential Inc
5620 West 99th Street
Bloomington, MN 55437

RE: Project Number(s) SL36953015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 22, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health note violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 . . ."

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**

**The total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

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

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

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

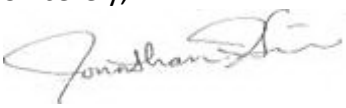
**REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



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

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36953 | A. BUILDING: _____ B. WING _____ | 10/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIDWEST RESIDENTIAL INC | 5620 WEST 99TH STREET BLOOMINGTON, MN 55437 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL36953015<br><br>On October 20, 2021, through October 22, 2021, the Minnesota Department of Health conducted a survey at the above provider and the following correction orders were issued. At the time of the survey, there were five (5) residents receiving services under the provider's Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for | 0 470 | | |

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

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| 0 470 | Continued From page 2<br>resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to include:<br>- Direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked.<br>- The direct-care staff members resident assignments or work location.<br>- Be posted after redacting direct-care staff members resident assignments, at the beginning of each work shift in a central location in each building.<br><br>On October 20, 2021, at 10:00 a.m., a tour of the licensee's building was conducted. A white board was observed in the dining room with staff names listed.<br><br>On October 20, 2021, at 10:10 a.m., the licensed assisted living director (LALD)-A indicated staff fill in their names when they come in to work a shift. LALD-A verified the lack of a daily staffing schedule to include the above required components.<br><br>The licensee's Staffing Policy & Plan policy dated August 1, 2021, indicated the clinical nurse supervisor would prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet resident's needs at all times. The policy also indicated the schedule would be posted at the beginning of the shift in a central | 0 470 | | |

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| 0 470 | Continued From page 3<br>location in each building, accessible to staff, residents, volunteers and the public.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all five residents receiving assisted living services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 480 | | |

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| 0 480 | Continued From page 4<br>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).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated, October 20, 2021, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interview and record review, the licensee failed to establish and maintain an effective infection control program | 0 510 | | |

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| 0 510 | Continued From page 5 | 0 510 | | |

that complied with accepted health care, medical and nursing standards for infection control related to COVID-19 and standards for infection control during medication administration per the Centers for Disease Control (CDC) and Minnesota Department of Health (MDH) guidelines. This had the potential to affect all five residents, staff, and visitors at the facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

The licensee failed to ensure staff wore eye protection while providing direct care.

Unlicensed personnel (ULP)-C did not wear gloves during nasal spray administration and did not wash hands in between nasal spray administration and oral medication administration.

On October 21, 2021, at 7:45 a.m., unlicensed personnel (ULP)-C was observed providing direct care to R1, including blood glucose check, insulin administration, nasal spray administration and oral medication administration.

ULP-C did not wear eye protection during direct care (medication administration).

ULP-C administered fluticasone 50 micrograms mcg (nasal spray) to R1 but did not wear gloves. ULP-C then proceeded to prepare and administer

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| 0 510 | Continued From page 6 | 0 510 | | |

oral medications without washing hands in between nasal spray and oral medication administration for R1. On October 21, 2021, at 8:00 a.m. ULP-C verified she forgot to wear gloves for the nasal spray administration and forgot to perform handwashing in between nasal and oral routes.

On October 21, 2021, at 8:59 a.m., licensed assisted living director (LALD)-A confirmed staff are no longer wearing eye protection, but did before when COVID-19 was a problem. LALD-A also confirmed ULP-C did not follow infection control protocol with medication administration.

The MDH guidance titled, "COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Settings," dated April 23, 2021, indicated on page 1 of 3, heath care worker (HCW) with face-to-face contact with COVID-19 negative residents are to wear eye protection.

The licensee's undated COVID Policy and Procedures policy indicated all staff providing direct care would wear PPE (personal protective equipment) and the PPE used would be based on many factors. The policy failed to include information on when to use eye protection.

The licensee's Skill Competency, Medication Routes protocol dated December 22, 2020, indicated staff would wash hands and apply gloves prior to nasal spray administration. The protocol also indicated staff would wash hands prior to setting up and administering oral medications.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7)

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| 0 510 | Continued From page 7<br>days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all five residents receiving assisted living services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include: | 0 550 | | |

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| 0 550 | Continued From page 8<br><br>The licensee lacked a posting in a common area of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of posting in the common area of contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br><br>On October 20, 2021, during a facility tour at approximately 10:45 a.m., an observation of the facility's common areas noted the lack of the required posting of the grievance procedure and Ombudsman contact information.<br><br>On October 20, 2021, at 11:00 a.m., the licensed assisted living director (LALD)-A verified the required information was not posted in the common areas of the facility and indicated someone must have taken it down.<br><br>The licensee's Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee would post in a conspicuous place, information about their complaint/grievance procedure, including the name, telephone number and email contact information for the individuals who are responsible for handling resident complaint/grievances. The policy also indicated the posting would have the contact information for the office of ombudsman for long term care and the ombudsman for mental health and developmental disabilities.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 0 550 | | |

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| 0 550 | Continued From page 9<br>(21) days | 0 550 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to post the required content in common areas to include: Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility and posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all five residents receiving assisted living services, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive | 0 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36953 | A. BUILDING: _____ B. WING _____ | 10/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIDWEST RESIDENTIAL INC | 5620 WEST 99TH STREET BLOOMINGTON, MN 55437 |

| (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 |
|---|---|---|---|---|
| 0 640 | Continued From page 10<br>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee lacked the following:<br>- posting of 911 emergency number in common areas and near telephones provided by the assisted living facility<br>- posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557<br><br>On October 20, 2021, at 10:00 a.m., an observation made of the facility main entry area and common areas noted a lack of the required posted information.<br><br>On October 20, 2021, at 10:10 a.m., the licensed assisted living director (LALD)-A confirmed the required content noted above had not been posted as required and indicated someone must have taken it down.<br><br>The licensee's Complaint /Grievance Posting policy dated, August 1, 2021, indicated the licensee would post information for reporting suspected maltreatment to the MAARC. The licensee lacked a policy regarding posting of 911 emergency numbers in common area and near telephones.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 0 790 | Continued From page 11 | 0 790 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(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<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure the correct portable fire extinguishers were on-site at the facility. This had the potential to directly affect all five residents and staff.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On October 22, 2021, at approximately 3:45 p.m. during facility tour with chief executive officer (CEO), surveyor observed the portable fire extinguisher on site was rated 5-B:C. CEO confirmed that the extinguisher was 5-B:C and | 0 790 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36953 | A. BUILDING: _____ B. WING _____ | 10/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MIDWEST RESIDENTIAL INC | 5620 WEST 99TH STREET BLOOMINGTON, MN 55437 |

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|---|---|---|---|---|
| 0 790 | Continued From page 12<br>stated he will be replacing it with the correct size.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 01620 SS=F | 144G.70 Subd. 2 Initial reviews, assessments, and monitoring<br><br>(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.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36953 | A. BUILDING: _____ B. WING _____ | 10/22/2021 |

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|---|---|---|---|---|
| 01620 | Continued From page 13<br>(RN) completed a comprehensive nursing assessment with all required content for one of one resident (R1) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1 was admitted for assisted living services with diagnoses including stroke, diabetes, and hypertension (high blood pressure).<br><br>R1's most recent Nurse Monitoring and Re-assessment dated August 20, 2021, failed to include all required assessment areas.<br><br>R1's assessment failed to include the following required content: toileting pattern; a review of medications that included reason medication taken, difficulties resident faces in taking the medication, and resident preferences in how to take the medications; a review of medical, dental, and emergency room visits in the past 12 months including visits to primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; a review of any report from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations in the last 12 months; initial vital signs; behavioral expressions of mental health conditions (eating disorder, agitation, depression with psychotic features); assessment of ability to smoke without causing burns, injury to resident, | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 36953 | A. BUILDING: _____ B. WING _____ | 10/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 01620 | Continued From page 14<br>others, or damage to property; and alcohol and drug use (not prescribed).<br><br>On October 20, 2021, at 10:30 a.m., RN-B confirmed the most recent re-assessment did not include all required assessment areas and indicated she was unaware of the need to include all required assessment areas.<br><br>The licensee's Nursing Uniform Assessment Tool policy dated, August 1, 2021, indicated the RN would use the uniform assessment tool that addresses all required elements.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 02310 SS=D | 144G.91 Subd. 4 Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R1) who utilized bed rails with record reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 36953 | A. BUILDING: _____ B. WING _____ | 10/22/2021 |

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|---|---|
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|---|---|---|---|---|
| 02310 | Continued From page 15 | 02310 | | |

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:
R1's record lacked a bed rail assessment and lacked documentation of the risks versus benefits of bed rail use.
R1 was admitted for assisted living services with diagnoses including stroke, diabetes, and hypertension (high blood pressure).
On October 20, 2021, at 10:30 a.m., R1's bed was observed to have bilateral black bed rails attached to an older style hospital bed. Both bed rails were wobbly (not tightened). The space between the mattress and the bed rail measured less than four inches. On October 20, 2021, at 10:35 a.m., registered nurse (RN)-B tried to tighten the bed rails using a circular knob located on each bed rail. At that time, R1 indicated using the bed rails as an aid to mobility.
On October 20, 2021, at 10:40 a.m., RN-B confirmed R1's record lacked a bed rail assessment and lacked documentation of the risks versus benefits of bed rail use.
The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters inches.

The Food and Drug Administration (FDA), "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

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|---|---|---|---|---|
| 02310 | Continued From page 16<br>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."<br><br>The licensee's policy on bed rail use was requested but not provided.<br><br>No further pertinent information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02310 | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *10/20/21*
Time: 08:49:18
Report: 1018211146

# Food and Beverage Establishment Inspection Report



**Location:**
MIDWEST RESIDENTIAL
5620 W 99TH STREET
Bloomington, MN55437
Anoka County, 02

**Establishment Info:**
ID #: N036953
Risk:
Announced Inspection: No

**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.

**3-300B Protection from Contamination: cross-contamination, eggs**

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE COOLER. DISCUSSED WITH MANAGER TO STORE RAW EGGS BELOW ANY READY TO EAT FOODS.

*Comply By: 10/20/21*

**3-500C Microbial Control: date marking**

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPENED PACKAGES OF DELI MEAT IN THE COOLER OBSERVED WITHOUT DATE MARK. DISCUSSED WITH MANAGER TO DATE MARK OPENED, TCS FOODS TO ENSURE THEY ARE NOT USED PAST 7 DAYS.

*Comply By: 10/20/21*

**Food and Equipment Temperatures**

Process/Item: Cold Holding/ BUTTER
Temperature: 37 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Type: Full
Date: *10/20/21*
Time: 08:49:18
Report: 1018211146
MIDWEST RESIDENTIAL

# Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

INSPECTION CONDUCTED WITH HRD STAFF, ANGELA RICHEY

DISCUSSED EMPLOYEE ILLNESS POLICIES AND VIEWED ILLNESS LOGS.

CFPM CERTIFICATE IN PROGRESS. FAIZA HASSAN WILL BE THE CERTIFIED FOOD PROTECTION MANAGER FOR THIS LOCATION.

FLOORS, WALLS AND CEILINGS ARE NOT APPROVED MATERIALS BUT ARE IN GOOD CONDITION.

CABINETS AND COUNTERTOPS ARE NOT APPROVED MATERIALS BUT ARE IN GOOD CONDITION.

FIRM DOES ONLY SAME DAY SERVICE.

DISHWASHER OBSERVED WITH SANITIZE FUNCTION.

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

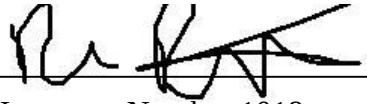
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018211146 of 10/20/21.

Certified Food Protection Manager: FAIZA HASSAN

Certification Number: _____ Expires: / /

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

Signed: _____
SANDOL KHALAF
MANAGER

Signed: 
Inspector Number 1018

6512014500

Report #: 1018211146

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

**Minnesota Department of Health**
**Environmental Health, FPLS**
**P.O Box 64975**
**Saint Paul**

| | | | |
|---|---|---|---|
| **No. of RF/PHI Categories Out** | 2 | **Date** | 10/20/21 |
| **No. of Repeat RF/PHI Categories Out** | 0 | **Time In** | 08:49:18 |
| **Legal Authority MN Rules Chapter 4626** | | **Time Out** | |

| | **Address** | **City/State** | **Zip Code** | **Telephone** |
|---|---|---|---|---|
| MIDWEST RESIDENTIAL | 5620 W 99TH STREET | Bloomington, MN | 55437 | |

| **License/Permit #** | **Permit Holder** | **Purpose of Inspection** | **Est Type** | **Risk Category** |
|---|---|---|---|---|
| N036953 | | Full | | |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

**IN=** in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| | **Supervision** | | | |
| 1 | IN OUT | PIC knowledgeable; duties & oversight | | |
| 2 | IN OUT N/A | Certified food protection manager, duties | | |
| | **Employee Health** | | | |
| 3 | IN OUT | Mgmt/Staff;knowledge,responsibilities&reporting | | |
| 4 | IN OUT | Proper use of reporting, restriction & exclusion | | |
| 5 | IN OUT | Procedures for responding to vomiting & diarrheal events | | |
| | **Good Hygenic Practices** | | | |
| 6 | IN OUT N/O | Proper eating, tasting, drinking, or tobacco use | | |
| 7 | IN OUT N/O | No discharge from eyes, nose, & mouth | | |
| | **Preventing Contamination by Hands** | | | |
| 8 | IN OUT N/O | Hands clean & properly washed | | |
| 9 | IN OUT N/A N/O | No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed | | |
| 10 | IN OUT | Adequate handwashing sinks supplied/accessible | | |
| | **Approved Source** | | | |
| 11 | IN OUT | Food obtained from approved source | | |
| 12 | IN OUT N/A N/O | Food received at proper temperature | | |
| 13 | IN OUT | Food in good condition, safe, & unadulterated | | |
| 14 | IN OUT N/A N/O | Required records available; shellstock tags, parasite destruction | | |
| | **Protection from Contamination** | | | |
| 15 | IN OUT N/A N/O | Food separated and protected | | |
| 16 | IN OUT N/A | Food contact surfaces: cleaned & sanitized | | |
| 17 | IN OUT | Proper disposition of returned, previously served, reconditioned, & unsafe food | | |

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| | **Time/Temperature Control for Safety** | | | |
| 18 | IN OUT N/A N/O | Proper cooking time & temperature | | |
| 19 | IN OUT N/A N/O | Proper reheating procedures for hot holding | | |
| 20 | IN OUT N/A N/O | Proper cooling time & temperature | | |
| 21 | IN OUT N/A N/O | Proper hot holding temperatures | | |
| 22 | IN OUT N/A | Proper cold holding temperatures | | |
| 23 | IN OUT N/A N/O | Proper date marking & disposition | | |
| 24 | IN OUT N/A N/O | Time as a public health control: procedures & records | | |
| | **Consumer Advisory** | | | |
| 25 | IN OUT N/A | Consumer advisory provided for raw/undercooked food | | |
| | **Highly Susceptible Populations** | | | |
| 26 | IN OUT N/A | Pasteurized foods used; prohibited foods not offered | | |
| | **Food and Color Additives and Toxic Substances** | | | |
| 27 | IN OUT N/A | Food additives: approved & properly used | | |
| 28 | IN OUT | Toxic substances properly identified, stored, & used | | |
| | **Conformance with Approved Procedures** | | | |
| 29 | IN OUT N/A | Compliance with variance/specialized process/HACCP | | |

**Risk factors** (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

## GOOD RETAIL PRACTICES

**Good Retail Practices** are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

| | | | COS | R |
|---|---|---|---|---|
| | | **Safe Food and Water** | | |
| 30 | IN OUT N/A | Pasteurized eggs used where required | | |
| 31 | | Water & ice obtained from an approved source | | |
| 32 | IN OUT N/A | Variance obtained for specialized processing methods | | |
| | | **Food Temperature Control** | | |
| 33 | | Proper cooling methods used; adequate equipment for temperature control | | |
| 34 | IN OUT N/A N/O | Plant food properly cooked for hot holding | | |
| 35 | IN OUT N/A N/O | Approved thawing methods used | | |
| 36 | | Thermometers provided & accurate | | |
| | | **Food Identification** | | |
| 37 | | Food properly labled; original container | | |
| | | **Prevention of Food Contamination** | | |
| 38 | | Insects, rodents, & animals not present | | |
| 39 | | Contamination prevented during food prep, storage & display | | |
| 40 | | Personal cleanliness | | |
| 41 | | Wiping cloths: properly used & stored | | |
| 42 | | Washing fruits & vegetables | | |

| | | | COS | R |
|---|---|---|---|---|
| | | **Proper Use of Utensils** | | |
| 43 | | In-use utensils: properly stored | | |
| 44 | | Utensils, equipment & linens: properly stored, dried, & handled | | |
| 45 | | Single-use/single service articles: properly stored & used | | |
| 46 | | Gloves used properly | | |
| | | **Utensil Equipment and Vending** | | |
| 47 | | Food & non-food contact surfaces cleanable, properly designed, constructed, & used | | |
| 48 | | Warewashing facilities: installed, maintained, & used; test strips | | |
| 49 | | Non-food contact surfaces clean | | |
| | | **Physical Facilities** | | |
| 50 | | Hot & cold water available; adequate pressure | | |
| 51 | | Plumbing installed; proper backflow devices | | |
| 52 | | Sewage & waste water properly disposed | | |
| 53 | | Toilet facilities: properly constructed, supplied, & cleaned | | |
| 54 | | Garbage & refuse properly disposed; facilities maintained | | |
| 55 | | Physical facilities installed, maintained, & clean | | |
| 56 | | Adequate ventilation & lighting; designated areas used | | |
| 57 | | Compliance with MCIAA | | |
| 58 | | Compliance with licensing & plan review | | |

**Food Recalls:**

**Person in Charge (Signature)** **Date:** 10/22/21

Inspector (Signature)