Electronically Delivered

May 21, 2024

Licensee
We Care Home Health Services, LLC
2000 Edinbrook Court
Brooklyn Park, MN 55443

RE: Project Number(s) SL36554015

Dear Licensee:

On April 19, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 6, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 16, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 6, 2023, found not corrected at the time of the April 19, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00

The details of the violations noted at the time of this follow-up survey completed on April 19, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on April 19, 2024, we identified the following violation(s):

1040-Notice Of Contract Termination Required-144g.52 Subd. 7

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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

IMPOSITION OF FINES:

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.

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

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

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

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	R 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. 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. INITIAL COMMENTS: SL36554015-2 On April 18, 2024, through April 19, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 6, 2023. At the time of the survey, there were five residents, all of whom received services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{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.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}		

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required.	{0 470}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:	{0 650}		

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{0 650}	Continued From page 2 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	{0 680}		

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{0 680}	Continued From page 3 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: No further action required.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (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	{0 780}		

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{0 780}	Continued From page 4 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: No further action required.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation for the health, safety, and well-being of the residents. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	{0 800}		

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{0 800}	Continued From page 5 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). On April 18, 2024, at 11:31 a.m., during a facility tour, the surveyor observed a four-level home with three occupied bedrooms on the upper level, no bedrooms on the main level, two occupied bedrooms on the lower level, and no bedrooms in the basement. There was a door in the lower-level common area with steps that led into the basement. Upon entry to basement the surveyor observed a musty odor. There were four groups of multiple dead terrestrial arthropods (bugs) and one area of material that appeared to be mouse droppings. The surveyor did not observe any mouse traps, glue traps, or evidence of pest control in the basement. Along the far-right side of the basement there were 15 circular marks on the floor. Two of the circular marks were black in color and 13 circular marks were copper color. In a section between the circular marks was a section with an irregular border that was dark grey and was wet in appearance. Within the dark section was an irregular patch of white growth which had raised parts. In the far-right corner, there was a sump pump basin (where rainwater collects from drain tile in the foundation of the house) with a black lid to cover the sump pump basin. The baseboard (strip where the floor and wall meet) adjacent to the sump pump basin had an irregular black stain pattern along the baseboard. The height of the irregular discoloration was 4 inches ("). On the floor close to the sump pump basin was a mix of brown and black discoloration with a strip of raised white growth that led toward the sump pump basin. Along from the section of wall adjacent to the sump pump, there was further discoloration along the section on the floor of	{0 800}		

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{0 800}	Continued From page 6 brown discoloration which extended out 24" with an irregular border. There was white growth with an irregular border on the floor growing out from the wall. There was another patch along the on the wall left of the sump pump that measured 24" in length that was black in color, with an irregular pattern, the further point out was 6" and appeared wet. Along the same wall, there was a small white drain lid that had a copper pipe attached to it. There was black discoloration with an irregular border that surrounded the white drain cover. The black discoloration had raised peeks of irregular shapes. In the left part of the basement, there was a small black refrigerator. On top of the refrigerator, not refrigerated, were the following food items: a packet of open grated cheese, a bottle of red sauce, a closed packet of cheese, a packet of hot dogs (on top of the cheese), a packet of cheese slices, a container of bologna, and a container of "CountryCrock original". On April 18, 2024, at 11:35 a.m., the surveyor inquired to supervisor/unlicensed personnel (S/ULP-E) why food was stored outside of the refrigerator. S/ULP-E stated the food was for staff only and it not for residents. On April 18, 2024, at 1:03 p.m., during a tour of the basement with registered nurse (RN)-B, RN-B stated the discoloration noted above was not visible mold and the floor was decolored related to the age, "every basement has that". RN-B stated the discoloration surrounding the drain, "it's just a stain". During this time, the surveyor observed the food had been removed from the top of the refrigerator. On April 18, 2024, at 1:24 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they made sure the rooms	{0 800}		

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{0 800}	Continued From page 7 are clean every day, and stated they had not seen what was noted above, and the last time they were in the basement was three weeks ago. On April 19, 2024, at 9:44 a.m., during the exit conference with LALD/CNS-C, they stated that was a how a "normal" basement appeared, and they would have a company inspect the basement. No information was provided.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	{0 810}		

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{0 810}	Continued From page 8 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal	01040		

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01040	Continued From page 9 representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to send a copy of the termination notice to the Office of Ombudsman for Long-Term Care for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at an isolated 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: R2 admitted to the licensee on November 18, 2023, and began receiving assisted living services. R2's progress note dated March 15, 2024, at 3:29 p.m., indicated licensed assisted living director (LALD/CNS)-C and case manager (CW)-H held a pre termination meeting with R2. The progress note indicated the reasons for termination included non-payment of rent, fire safety concerns including lighting candles, burning incense, and blocking the window with a mattress.	01040		

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01040	Continued From page 10 R2's progress note dated April 9, 2024, at 4:39 p.m., indicated LALD/CNS-C contacted the Ombudsman via the telephone to report the eviction notice given to R2. R2's progress note dated April 10, 2024, at 2:28 p.m., indicated LALD/CNS-C received a telephone call from the Ombudsman office that requested the licensee contact the Long-Term Care Ombudsman. On April 18, 2024, at 9:19 a.m., the surveyor observed R2's personal effects being moved from the lower level of the house into a pickup truck parked on the driveway. On April 18, 2024, at 12:43 p.m., the licensee provided a document titled [licensee] Termination Of AL Contract for R2. The documented indicated the assisted living contract was being terminated effective April 22, 2024. R2's chart lacked evidence written notice was given to The Office of Office of Ombudsman for Long-Term Care. On April 18, 2024, at 1:22 p.m., the surveyor inquired to LALD/CNS-C if a written notice had been provided to The Office of Ombudsman for Long-Term Care for R2. LALD/CNS-C stated they were aware of the requirement, and "I skipped it for some reason". On April 19, 2024, at 12:48 p.m., via email, the Office of Ombudsman for Long-Term Care indicated to the surveyor the licensee had not provided contract termination notice for R2. No information was provided.	01040		

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01040	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01040		
{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, 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	{01060}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	R 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

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{01060}	Continued From page 12 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: No further action required.	{01060}		
{01070} SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: No further action required.	{01070}		
{01290} SS=F	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 an employee in good faith	{01290}		

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{01290}	Continued From page 13 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: No further action required.	{01290}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving	{01370}		

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{01370}	Continued From page 14 the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required.	{01370}		
{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 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	{01620}		

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{01620}	Continued From page 15 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: No further action required.	{01620}		
{01810} SS=E	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: No further action required.	{01810}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		
{01890} SS=E	144G.71 Subd. 20 Prescription drugs	{01890}		

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{01890}	Continued From page 16 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action required.	{01890}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}		

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{01910}	Continued From page 17 No further action required.	{01910}		
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: No further action required.	{02290}		

Electronically Delivered

March 1, 2024

Licensee
We Care Home Health Services, LLC
2000 Edinbrook Court
Brooklyn Park, MN 55443

RE: Project Number(s) SL36554015

Dear Licensee:

On February 21, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 6, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 6, 2023 survey.

last survey, completed on December 6, 2023, found not corrected at the time of the February 21, 2024, follow-up survey subject to penalty assessment are as follows:

0830-Local Laws Apply-144g.45 Subd. 3 - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on February 21, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

IMPOSITION OF FINES:

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.

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

correction order receipt date.

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

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

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	R 02/21/2024

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{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. 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. INITIAL COMMENTS: SL36554015-1 On February 21, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 6, 2023. At the time of the survey, there were four residents, all of whom received services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	{0 470}		

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{0 470}	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required.	{0 470}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	{0 650}		

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{0 650}	Continued From page 2 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	{0 680}		

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{0 680}	Continued From page 3 (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: No further action required.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (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	{0 780}		

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{0 780}	Continued From page 4 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: No further action required.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	{0 810}		

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{0 810}	Continued From page 5 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 830} SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by:	{0 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	R 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 830}	Continued From page 6 Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three of four residents (R2, R4, R5). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 21, 2024, at 9:12 a.m., upon entrance to the facility, the surveyor smelled a cigarette odor. On February 21, 2024, at 9:35 a.m., during facility tour, the surveyor observed a four-level home with three occupied bedrooms on the upper level, no bedrooms on the main level, one occupied bedroom and one unoccupied bedroom on the lower level, and no bedrooms in the basement. In the licensee's attached garage attached were six individual areas that contained over 20 discarded used cigarette filters and one area of ashes. R2 R2 was admitted to the facility on November 18, 2023, and resided on the lower level of the facility. R2's diagnoses included bipolar disorder (a mental illness characterized by extreme mood swings), glaucoma, hypertension, and diabetes.	{0 830}		

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{0 830}	Continued From page 7 R2's Service Plan (waiver) - Addendum to Contract dated November 19, 2023, indicated R2 received assistance with activity assistance, ambulation, application of lotion, appointment reminder/assistance, assistance with grooming, bathing reminder, bedmaking, dressing assistance/reminder, housekeeping, laundry, linen change, manage behavior management, meal assistance, medication administration, vital signs (VS), safety check, shopping assistance, and symptom screen. R2's progress note dated January 29, 2024, at 6:35 a.m., indicated staff observed R2 smoking in the garage. The progress note lacked interventions to prevent repeat smoking occurrences. R2's progress note dated February 5, 2024, at 6:07 a.m., indicated R2 had been in and out smoking through the night and was currently in the garage. The progress note lacked interventions to prevent repeat smoking occurrences. R2's progress note dated February 19, 2024, at 6:15 a.m., read, "Staff arrived by 8:00 and met client by the dining room table, client left by 8:30 to smoke in the garage and returned 9:30 to take his medication." The progress note lacked interventions to prevent repeat smoking occurrences. R2's progress note dated February 21, 2024, at 6:22 a.m., indicated R2 went to the garage to smoke. The progress note lacked interventions to prevent repeat smoking occurrences. On February 21, 2024, at 9:21 a.m., the surveyor	{0 830}		

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{0 830}	Continued From page 8 inquired about smoking in the facility. R2 stated they did not want to answer questions related to smoking, and that they believed second-hand smoke was coming through the window, causing the odor in the home. R2 stated they have observed residents, "lighting up" in the garage and then walking out. R4 R4 was admitted to the facility on February 17, 2021, and resided on the upper level of the facility. R4's diagnoses included schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), and bipolar. R4's Service Plan (waiver) - Addendum to Contract indicated R4 received assistance with activity assistance, appointment reminder, bathing reminder, bedmaking, housekeeping, and laundry. R4's progress note dated January 23, 2024, at 7:16 a.m., indicated the R4 went to the garage and later returned to his room. On February 21, 2024, at 9:29 a.m., R4 stated residents smoked cigarettes and vaped with the garage door open or closed. R5 R5 was admitted to the facility on April 6, 2022, and resided on the upper level of the facility. R5's diagnoses included major depression, attention deficit hyperactivity disorder (ADHD), and binge eating disorder.	{0 830}		

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{0 830}	Continued From page 9 R5's Service Plan (waiver) - Addendum to Contract signed August 1, 2023, indicated R5 received assistance with activity assistance, appointment reminder, bathing reminder, and bedmaking. R5's Nursing Assessment/Check in Registered Nurse (RN) Visit Note dated February 9, 2024, read, "client loves staying in the garage to smoke." The nurse assessment lacked interventions by staff related to smoking. On February 21, 2024, at 9:42 a.m., R5 stated residents smoked outside or in the garage with the garage door open or closed. R5 stated they mainly vape inside the facility but not often. On February 21, 2024, at 9:45 a.m., R6 stated residents smoked inside the garage and outside of the facility, and approximately one month ago they witnessed residents smoking in the garage with the door closed. On February 21, 2024, at 10:04 a.m., unlicensed personnel (ULP)-A stated they educated residents not to smoke in their rooms, and had observed residents smoking in the garage. ULP-A stated they would document the behavior and would inform the supervisor. On February 21, 2024, at 10:18 a.m., licensed assistant living director/clinical nurse supervisor (LALD/CNS)-C stated if staff detect smoke odor, to contact the LALD/CNS. LALD/CNS-C stated the discarded cigarette filters were from a previous resident. ULP-A stated R5 went to the garage with a container that cigarette filters that spilled. LALD/CNS-C stated the residents smoked in the designated area in the backyard, and the	{0 830}		

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{0 830}	Continued From page 10 cigarette filters in the garage were probably from a previous resident. LALD/CNS-C denied knowing residents were smoking or vaping in the facility or garage and stated if a resident was observed smoking in the garage or facility, staff would redirect the resident, update the case manager and if the behavior continued, the eviction process would be started. LALD/CNS-C stated they did not have any resident going through the eviction process. On February 21, 2024, at 10:37 a.m., ULP-G stated R2 was the only resident in the facility who smoked in the garage in the overnight hours. The surveyor inquired what the ULP would do if they saw R2 smoking in the garage. ULP-G stated they would document it in a progress note. ULP-G stated they observed R2 smoking inside the facility at the table, and they redirected R2 to go outside. ULP-G stated the last time they cleaned the garage floor of cigarette filters was "this morning before they took out the garbage." The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in all indoor public places and indoor places of employment including health care facilities and clinics. In addition, vaping and smoking cannabis products was included in the definition of smoking under the MCIAA. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility,	{0 830}		

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{0 830}	Continued From page 11 or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. The licensees undated Smoking Policy indicated Smoking is expressly forbidden within all indoor spaces, including rooms, corridors, and other enclosed areas of the facility. In addition, a separate smoking area will be situated away from entryways, exits, windows, air intakes, and any regions where smoke might infiltrate the facility. Appropriate signages will mark these areas. The licensee's Tobacco-Free policy dated April 14, 2023, indicated no use of tobacco products, including cigarettes, smokeless tobacco, and electronic cigarettes, is permitted within the facilities or on the licensee's property at any time. No further information provided.	{0 830}		
{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, 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	{01060}		

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{01060}	Continued From page 12 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: No further action required.	{01060}		
{01070} SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated.	{01070}		

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{01070}	Continued From page 13 This MN Requirement is not met as evidenced by: No further action required.	{01070}		
{01290} SS=F	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 an employee 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: No further action required.	{01290}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens;	{01370}		

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{01370}	Continued From page 14 (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required.	{01370}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	{01620}		

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{01620}	Continued From page 15 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}		
{01810} SS=E	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate.	{01810}		

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{01810}	Continued From page 16 This MN Requirement is not met as evidenced by:	{01810}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		
{01890} SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action required.	{01890}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	{01910}		

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{01910}	Continued From page 17 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required.	{01910}		
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: No further action required.	{02290}		

Electronically Delivered

January 4, 2024

Licensee
We Care Home Health Services, LLC
2000 Edinbrook Court
Brooklyn Park, MN 55443

RE: Project Number(s) SL36554015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 6, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply = $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each

matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36554015-0 On December 4, 2023, through December 6, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on December 5, 2023, issued for SL36554015-0, tag identification 0830. On December 6, 2023, the immediacy of correction order 0830 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living license. The facility was licensed for a bed capacity of five residents and had a current census of five residents. On December 6, 2023, at approximately 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided the surveyor with an undated staffing plan titled Staffing Plan 2022 (Partridge Home). The staffing plan was named after a sister facility and lacked an evaluation conducted by the CNS, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On December 6, 2023, at 11:31 a.m., the surveyor inquired if the staffing plan listed above was the staffing plan for the licensee because it was titled after a sister facility. LALD/CNS-C provided the surveyor with an undated document titled Staffing Schedule which included the following information: two shifts, activity coordinator, room assignments, home health aide, lead staff, and person in charge. LALD/CNS-C stated the document was what they used for the staffing plan. In addition, LALD/CNS-C stated the Staffing Schedule document was updated every two weeks and as needed. The staffing schedule lacked an evaluation conducted by the CNS, of the	0 470		

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0 470	Continued From page 3 appropriateness of staffing levels in the facility. LALD/CNS-C stated they understood the requirement, however, did not know it needed to be documented on twice per year. The licensee's staffing policy, dated August 1, 2021, indicated the staffing plan was based on an evaluation of the appropriateness of the staffing levels in the facility and was reviewed at least twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	0 650		

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0 650	Continued From page 4 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on July 2, 2020, to provide direct care to residents. ULP-A's employee record lacked the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - performance review. On December 5, 2023, at 2:06 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated they thought the items listed above were in the ULP-A'S employee record. LALD/CNS-C looked through the record but was unable to find the documents. On December 5, 2023, at 2:38 p.m.,	0 650		

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0 650	Continued From page 5 LALD/CNS-C provided the surveyor a performance evaluation for ULP-A dated December 5, 2023, completed during survey. The licensee's Personnel Records policy dated August 1, 2021, read, "1. A personnel record will be started for each staff member upon hire. 2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: o Evidence of current professional licensure, registration or certification o Results of background studies o Records of annual training and infection control training o Documentation of orientation o Documentation of supervision, as applicable o Performance reviews o Competency evaluations o Signed job description o Documentation of annual performance reviews identifying areas of improvement needed and training needs 3. A job description is maintained that includes qualifications, responsibilities and identification of supervisors for each job classification." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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0 680	Continued From page 6 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must 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 maintain a written emergency preparedness plan (EPP) 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 7 The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - quarterly review of missing resident policy; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - policies and procedures for medical documents; - arrangement with other facilities to include arrangement agreements; - roles under a waiver declared by secretary; - methods for sharing information; and - emergency prep testing requirements. On December 4, 2023, during the facility tour, the surveyor did not see an evacuation plan posted on the lower level of the facility. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C showed the surveyor where they had previously posted the diagram and stated a resident may have removed the document. On December 6, 2023, at 12:07 a.m., LALD/CNS-C said they kept separate emergency preparedness binders for each facility they managed in the office (different address) and had a copy of the EPP on RTask (a documenting software system) for staff to access. The surveyor inquired why the binders referenced a different address than the facility address. LALD/CNS-C stated they used the office address for all facilities. The licensee's Emergency Preparedness* policy dated August 1, 2021, indicated the licensee had an identified plan in place to assure the safety and well-being of residents and staff during	0 680		

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0 680	Continued From page 8 periods of an emergency or disaster that disrupted services. The licensee would post on each floor and evacuation plan and provide to all residents upon admission. In addition, a disaster drill was conducted at the residence at least annually and results of the drill would be documented. 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 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in	0 780		

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0 780	Continued From page 9 existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. 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). The findings include: On a facility tour on December 5, 2023, at 9:00 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, it was observed smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. During the tour, a smoke alarm test button was activated upstairs and the smoke alarms in the resident rooms and in the lower level did not activate. All dwelling units (the whole building) required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms throughout the facility. On December 5, 2023, at 9:00 a.m., LALD/CNS-C, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility during	0 780		

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0 780	Continued From page 10 the testing. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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 directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on December 5, 2023, at 9:00	0 800		

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0 800	Continued From page 11 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, the surveyor made the following observations of facility hazards and disrepair: There was a hole near the base of the wall because a heat vent cover was removed in resident room #1. A barricade was in place over the exterior door leading outside from the garage to the rear yard. The garage was used by residents of the facility and doors are required to be maintained with egress hardware as installed at the time of construction approval. During a facility tour on December 5, 2023, at 9:00 a.m., LALD/CNS-C 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 12 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. 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:	0 810		

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0 810	Continued From page 13 READILY AVAILABLE During an interview on December 6, 2023, at 9:30 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated the fire safety and evacutation plan (FSEP) for resident instructions to take in case of a fire or other emergency documentation was available in the residents file but was not kept with the FSEP and available for immediate use in a fire or similar emergency. On December 6, 2023, LALD/CNS-C provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP failed to include the following: The number of resident sleeping rooms was not accurate on the basement floor plan. LALD/ CNS-C stated the room labeled (Room 1) was not a sleeping room and was a storage room for supplies. The FSEP floor plan is required to reflect include accurate identification and location of rooms. The FSEP did not identify specific fire protection actions for residents evident by not including language for actions required of the residents during a fire or similar emergency. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include needs for each individual resident's evacuation during a fire	0 810		

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	36554	A. BUILDING: _____ B. WING _____	12/06/2023

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0 810	Continued From page 14 or similar emergency. During an interview on December 6, 2023, at 9:30 a.m., LALD/CNS-C stated this documentation was available in the residents file but was not kept with the FSEP and available for immediate use in a fire or similar emergency. Resident fire safety and evacuation plan records were requested and not provided. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by the FSEP training being documented as part of the fire drills. FSEP training is required to be completed and documented separate from the fire drills. During an interview on December 6, 2023, at 9:45 a.m., LALD/ CNS-C stated the FSEP training was completed as part of the fire drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable	0 830	On December 6, 2023, the immediacy of correction order 0830 was removed,	

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0 830	Continued From page 15 state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 4, 2023, at 10:02 a.m., upon entrance to the facility, the surveyor smelled a cigarette and cannabis odor at the main entrance. On December 4, 2023, 11:13 a.m., during a facility tour, the surveyor observed a four-level home with three occupied bedrooms on the upper level, no bedrooms on the main level, two occupied bedrooms on the lower level, and no bedrooms in the basement. The cigarette and cannabis odors were evident throughout the facility. The surveyor noted a stronger odor of cannabis on the lower level of the facility. The outdoor area had two locations designated for smoking, one on the wooden patio on the upper level, and one on the lower-level cement patio. Each contained an appropriate receptacle to extinguish a cigarette. On December 4, 2023, at 12:49 p.m., in R1's room, the surveyor observed ashes on the ground, and a small dish that contained ashes and a previously burned hand rolled cigarette filled with an unknown substance on R1's floor by	0 830	however non-compliance remained, and the scope and level remained unchanged.	

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0 830	Continued From page 16 the closet. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated, "so he likes to smoke in room once in a while, so it looks like he did today." LALD/CNS-C stated they have provided reeducation for not smoking in the facility and have talked to case manager regarding smoking in the facility. LALD/CNS-C stated they attempted to provide R1 with a termination notice and R1 refused to sign the notice and told the licensee they would stop smoking in the facility. CNS-C stated they did not keep the termination notice because R1 did not sign the notice. In addition, LALD/CNS-C stated R1's smoking did bother other residents and they have called the police on R1 when they would not stop smoking. R1 admitted to the licensee on December 1, 2022, and began receiving assisted living services. R1's diagnoses included quadriplegia (paralysis caused by illness or injury that results in partial or total loss of use of all their limbs and torso), major depression, generalized anxiety disorder, asthma, hypertension, edema of the throat, and bipolar (mental disorder characterized by periods of depression and periods of abnormally elevated moods). R1's record included two emails dated June 15, 2023, and June 20, 2023, from licensee to R1's case worker which discussed R1's smoking within the facility, aggressive behavior when asked to stop, and call to 911 on June 16, 2023. R1's Master Care Plan dated July 18, 2023, indicated an assessment related to smoking was conducted and R1 was deemed safe to smoke, was aware of the safe smoking areas, and was	0 830		

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0 830	Continued From page 17 compliant. In addition, staff redirected R1 daily to not smoke in room and R1 understood they could face eviction if behavior continued. R1's Service Plan Waiver- Addendum to Contract dated August 1, 2023, indicated R1 received assistance with activities, ambulation, lotion application, grooming, bathing, bed making, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, safety checks, and shopping assistance. R1's record included an incident report dated August 6, 2023, which indicated R1 smoked in the facility, staff and other residents made a complaint about suffocating from the smoke smell. The incident report indicated a registered nurse (RN) discussed with resident the violation of house rules related to smoking and discussed eviction. R1 then told the RN he understood and promised not to smoke inside the facility again. R1's record included an incident report dated August 7, 2023, which indicated R1 smoked cannabis in the facility and refused to smoke outside. RN discussed with resident about smoking in the facility and contacted R1's case worker. R1's record included safety checks dated October 1, 2023, through December 5, 2023, documented on twice per day by unlicensed personnel (ULP). The instructions of the safety check instructed ULP would perform a visual safety check every hour and as needed. R1's record included an incident report dated November 19, 2023, which indicated R1 smoked cannabis in the facility and the entire facility	0 830		

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0 830	Continued From page 18 smelled of cannabis. R1 refused redirection and refused to smoke outside. In addition, staff and residents were "not happy about his actions." The incident report indicated the RN spoke with R1 related to smoking in facility and if smoking continued, they would be "evicted" from the facility. R1 stated they understood and promised not to smoke inside the facility again. On December 4, 2023, at 2:35 p.m., ULP-A stated R1 had smoked in the facility since admission. ULP-A stated R1 would lock themselves in their room and smoke, and when staff attempt to intervene, R1 will become abusive to the staff and become "very aggressive." ULP-A stated they notified the RN when R1 smoked in the facility. The surveyor inquired how frequently R1 smoked in the facility. ULP-A stated multiple times per week, "he smokes anytime he feels like it." On December 4, 2023, at 3:28 p.m., caseworker (C)-D stated they had talked to the licensee twice over the past three months. C-D stated the licensee discussed R1's smoking and how they were not a "big fan" however, did not say R1 could not smoke. The surveyor inquired if they ever discussed termination of contract with the licensee. C-D stated no. On December 4, 2023, at 3:33 p.m., LALD/CNS-C stated they attempted to keep smoking paraphernalia with staff when R1 was not smoking however, R1 refused. LALD/CNS-C stated they performed hourly safety checks on R1. The surveyor inquired how often LALD/CNS-C saw R1 smoke in the facility. LALD/CNS-C stated it ranged from zero to two times per week depending on R1's mood and the weather outdoors.	0 830		

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0 830	Continued From page 19 On December 5, 2023, at 10:09 a.m., the surveyor attempted to interview R1. R1 declined interview and stated he did not want to talk. On December 5, 2023, at 10:12 a.m., ULP-A stated R1 was independent with ambulation however, R1 experienced difficulty with ambulation with stairs and held on to the wall during ambulation. ULP-A stated R1 had an electric scooter used for distance. In addition, ULP-A stated would sometimes exit the facility on the lower-level patio door and smoke right outside the doorway. On December 5, 2023, at 10:28 a.m., although requested, the surveyor had not received evidence a termination or eviction notice was provided to R1. The licensee's undated document titled House Rules / Expectation, indicated absolutely no drug use or alcohol and no smoking anywhere within the house, including rooms, bathrooms, smoking was only permitted in the designated area. The licensee's undated rules and Regulation policy, indicated smoking was allowed outside the building within the designated smoking areas but not in bedrooms, bathrooms, or common living areas within the facility. In addition, the smoking time was between 6:00 a.m. and 10:00 p.m. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in all indoor public places and indoor places of employment including health care facilities and clinics. In addition, vaping and smoking cannabis products was included in the	0 830		

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0 830	Continued From page 20 definition of smoking under the MCIAA. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 830		
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, 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	01060		

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01060	Continued From page 21 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 a resident's emergency relocation to the resident, legal representative, or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of one resident (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	01060		

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01060	Continued From page 22 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: R3 admitted to the licensee on November 4, 2020, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R3's Service Plan signed September 30, 2020, indicated R3 received assistance with housekeeping, medication set up, meal preparation, shopping, medication administration, non-medical transportation, behavior management, assistance with appointments, activities of daily living (ADL's), laundry, and activities. R3's nursing progress notes dated November 1, 2023, through November 16, 2023, indicated R3 was hospitalized on November 9, 2023, for confusion. On November 15, 2023, R3 was transported to another hospital for an inpatient stay for psychiatric assessment. On November 16, 2023, R3 was discharged from the licensee. R3's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On December 6, 2023, at 11:07 p.m., licensed	01060		

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01060	Continued From page 23 assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they did not provide R3 with an emergency relocation notice nor did they contact OOLTC after R3 relocated greater than four days. CNS-C stated they have not provided relocation notices to any resident hospitalized however; they keep the resident's "spot" available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee infringed upon one of one resident's (R3) right to return to the facility after hospitalization without providing a written notice of termination. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01070		

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01070	Continued From page 24 R3 admitted to the licensee on November 4, 2020, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R3's Service Plan signed September 30, 2020, indicated R3 received assistance with housekeeping, medication set up, meal preparation, shopping, medication administration, non-medical transportation, behavior management, assistance with appointments, activities of daily living (ADL's), laundry, and activities. R3's Resident Agreement Assisted Living signed October 10, 2021, included page 5 section C titled Termination by the Community, and indicated the licensee may terminate the agreement by providing at least 30 days advanced written notice. In addition, page 7 section 11 titled Emergency Relocation, and indicated an emergency relocation was not a termination of the agreement. R3's nursing progress notes dated November 1, 2023, through November 16, 2023, indicated R3 was hospitalized on November 9, 2023, for confusion. On November 15, 2023, R3 was transported to another hospital for an inpatient stay for psychiatric care. On November 16, 2023, R3 was discharged from the licensee. On December 6, 2023, at 11:07 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had received a phone call from R3's case worker stating they were transferring R3 to a different hospital, and the licensee could release the bed. LALD/CNS-C stated R3 was upset that the licensee did not take	01070		

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01070	Continued From page 25 them back at the facility. The surveyor inquired if they provided a written termination notice or if the resident provided the licensee a written letter of termination. LALD/CNS-C stated no. LALD/CNS-C stated they admitted R2 to R3's room two days after receiving the phone call because R2 had been on the waiting list for a period of time. In addition, LALD/CNS-C stated when they heard R3 wanted to come back to the facility, they offered a room to R3 at a sister facility. The licensee's Discharged of Client policy dated March 24, 2021, indicated the licensee would prove at least thirty-day advance notice of termination of a service by the provider. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01070		
01290 SS=F	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 an employee 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	01290		

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01290	Continued From page 26 liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of five employees (unlicensed personnel (ULP)-A, ULP-E, ULP-G). 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: ULP-A ULP-A was hired on July 2, 2020, to provide direct care to residents. On December 5, 2023, at 8:05 a.m., the surveyor observed ULP-A administer oral medications to R6. ULP-A's employee record contained a background study clearance dated March 28, 2023, affiliated to licensee's sister facility HFID 37536. ULP-B's record lacked evidence the licensee submitted a background study for ULP-A under the current assisted living license and affiliated to the current HFID number. ULP-E ULP-E was hired on October 27, 2020, to	01290		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 27 supervise the staff at the facility and provide direct care to residents. ULP-E's employee record contained a background study clearance dated March 28, 2023, affiliated to licensee's sister facility HFID 37536. ULP-E's record lacked evidence the licensee submitted a background study for ULP-E under the current assisted living license and affiliated to the current HFID number. ULP-G ULP-G was hired on July 27, 2022, to provide direct care to residents. ULP-G's employee record contained a background study clearance dated March 28, 2023, affiliated to licensee's sister facility HFID 37536. ULP-G's record lacked evidence the licensee submitted a background study for ULP-G under the current assisted living license and affiliated to the current HFID number. On December 5, 2023, at approximately 1:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they realized some of the employees were not affiliated with the licensee's HFID, when they printed the background study roster for the survey. LALD/CNS-C stated they affiliated ULP-A before they printed the roster. The licensee's Personnel Records policy dated August 1, 2021, read, "1. A personnel record will be started for each staff member upon hire. 2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: o Evidence of current professional licensure, registration or certification	01290		

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01290	Continued From page 28 o Results of background studies o Records of annual training and infection control training o Documentation of orientation o Documentation of supervision, as applicable o Performance reviews o Competency evaluations o Signed job description o Documentation of annual performance reviews identifying areas of improvement needed and training needs." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to	01370		

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01370	Continued From page 29 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-A was hired on July 2, 2020, to provide	01370		

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01370	Continued From page 30 direct care to residents. On December 5, 2023, at 8:05 a.m., the surveyor observed ULP-A administer oral medications to R6. ULP-A's employee record lacked the following competency evaluations: - standby assistance techniques and how to perform them. On December 5, 2023, at 2:32 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they did not know training for the above-mentioned item was required in 2020 when ULP-A was hired. The Staff Competency policy dated August 1, 2021, read: "Training and competency evaluations for all unlicensed personnel include the following. Refer to the Competency Manual for criteria. Unlicensed personnel may not work for We Care Home Health Services until they have successfully passed the written (at 80%) and demonstration competency evaluation. a. Documentation requirements for all services provided b. Reports of changes in the resident's condition to the supervisor designated by the home care provider c. Basic infection control, including blood-borne pathogens d. Maintenance of a clean and safe environment e. Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting f. Training on the prevention of falls for providers	01370		

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01370	Continued From page 31 working with the elderly or those at risk of falls g. Standby assistance techniques and how to perform them h. Medication, exercise and treatment reminder i. Basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating j. Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family k. Awareness of confidentiality and privacy l. Understanding appropriate boundaries between staff, residents and the resident's family m. Procedures to utilize in handling various emergency situations n. Awareness of commonly used health technology equipment and assistive devices" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
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	01620		

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01620	Continued From page 32 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 admitted to the licensee on December 1, 2022, and began receiving assisted living services.	01620		

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01620	Continued From page 33 R1's diagnoses included quadriplegia (paralysis caused by illness or injury that results in partial or total loss of use of all their limbs and torso), major depression, generalized anxiety disorder, asthma, hypertension, edema of the throat, and bipolar (mental disorder characterized by periods of depression and periods of abnormally elevated moods). R1's Service Plan Waiver- Addendum to Contract dated August 1, 2023, indicated R1 received assistance with activities, ambulation, lotion application, grooming, bathing, bed making, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, safety checks, and shopping assistance. R1's record included 90-day nursing assessments dated April 18, 2023, and July 18, 2023. The assessment completed on July 18, 2023, indicated 91 days had passed between assessments. On December 6, 2023, at 11:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R1's assessment may have been late due to R1's aggressive behaviors. LALD/CNS-C stated they will not conduct the assessment and leave if R1 "swears" at them. The surveyor inquired if they had documentation to show the assessment being late due to R1's behaviors. The surveyor did not receive documentation from LALD/CNS-C of an assessment attempted to be conducted for R1 throughout the survey. In addition, LALD/CNS-C stated they tried to schedule all resident ongoing assessments seven days prior to the due date to avoid being late.	01620		

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01620	Continued From page 34 The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01810 SS=E	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure over-the-counter (OTC) drugs were stored as appropriate for two of five resident (R1, R5). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01810		

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01810	Continued From page 35 found to be pervasive). The findings include: On December 5, 2023, at 8:05 a.m., the surveyor conducted a review of the licensee's two medication file cabinets which contained five resident's medications and observed the following expired medications: - R1's acetaminophen 500 milligrams (mg) tablet with an expiration date of November 23, 2023; and - R5's acetaminophen with an expiration date of November 2023, vitamin D3 with an expiration date of June 9, 2023. On December 5, 2023, at 8:12 a.m., unlicensed personnel (ULP)-A stated if they found a medication expired in the medication file cabinets, they would remove the medication from the cabinet and provide the medication to the nurse to dispose of. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP called them if there was an expired medication in the cabinet and they would dispose the medication. In addition, LALD/CNS-C stated they reviewed the medication file cabinets when they completed medication reconciliations monthly. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated discontinued medication would be kept until the expiration dates if there was a possibility of resuming the medication and if not resumed before the expiration date it would be disposed of according to the policy. No further information provided.	01810		

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01810	Continued From page 36 TIME PERIOD FOR CORRECTION: Seven (7) days	01810		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked location for one of five 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) 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 admitted to the licensee on November 18, 2023, and began receiving assisted living services. R2's diagnoses included, bipolar (mental illness that causes extreme mood swings, from high to low, that affect your energy, thinking, and behavior), diabetes, glaucoma, and hypertension. R2's Service Plan (Wavier) - Addendum to	01880		

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01880	Continued From page 37 Contract signed November 19, 2023, indicated R2 received assistance with activities, ambulation, lotion application, grooming, bathing, bedmaking, dressing, housekeeping, laundry, behavior management, medication administration, and weekly vital signs. On December 4, 2023, at 11:13 a.m., during a facility tour, the surveyor observed one bottle of Systane eye drop, fluticasone 50 microgram (mcg) nasal spray, and an albuterol sulfate 90 mcg (microgram) inhaler in R2's room on the nightstand. R2's 14-day assessment completed on December 1, 2023, indicated R2 needed medication administration provided by staff, often forgot to take medications, and may forget to take medication if staff does not offer them. In addition, R2's medication were locked in a locked cabinet, medication refrigerator was available to store temperature sensitive medications, and R2 performed their own blood glucose test. On December 5, 2023, at 8:12 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated medications should be locked in the medication file cabinets when not in use. The licensee's Storage/Control of Medications dated August 1, 2021, indicated the licensee was providing storage of medications outside of the resident's private living space, all prescription drugs were securely locked in substantially constructed compartments according to the manufacturer's directions. No further information was provided.	01880		

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01880	Continued From page 38 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for two of five residents (R1, R5). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 5, 2023, at 8:05 a.m., the surveyor conducted a review of the licensee's two medication file cabinets which contained five resident's medications and observed the following expired medications: - R1's baclofen with an expiration date of	01890		

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01890	Continued From page 39 November 23, 2023; and - R5's buspirone 5 mg with an expiration date of November 29, 2023. On December 5, 2023, at 8:12 a.m., unlicensed personnel (ULP)-A stated if they found a medication expired in the medication file cabinets, they would remove the medication from the cabinet and provide the medication to the nurse to dispose of. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP called them if there was an expired medication in the cabinet and they would dispose the medication. In addition, LALD/CNS-C stated they reviewed the medication file cabinets when they completed medication reconciliations monthly. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated discontinued medication would be kept until the expiration dates if there was a possibility of resuming the medication and if not resumed before the expiration date it would be disposed of according to the policy. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been	01910		

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01910	Continued From page 40 discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was discharged from the licensee on	01910		

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01910	Continued From page 41 November 16, 2023. R3's diagnoses included substance use disorder, vitamin D deficiency, hyperlipemia (high cholesterol), other psychoactive substance abuse, bipolar disorder (mental illness that causes extreme mood swings, from high to low, that affect your energy, thinking, and behavior), schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), cognitive disorder, antisocial personality disorder, and diabetes. R3's Med Amin Summary - Actual - Month dated November 1, 2023, through November 30, 2023, indicated the last day the licensee administered medication to R3 was November 9, 2023, and the following medications were administered in the month of November: amlodipine 10 milligrams (mg), aspirin 81 mg, vitamin D 3 25 micrograms (mcg), losartan potassium 75 mg, metformin 500 mg , metoprolol 25 mg, clonazepam 0.5 mg, lamotrigine 100 mg, melatonin 3 mg, Refresh Lacri-Lube eye ointment, Stimulant Laxative 8.6 mg/ 50mg, Atorvastatin 40 mg, and clozapine 100 mg. R3 Discharge - Transfer Summary indicated R3's medications were destroyed on November 16, 2023, and were documented in RTasks (documenting software system). On December 6, 2023, at 7:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R3 went to the hospital, and the licensee was going to admit R3 at a sister facility. LALD/CNS-C stated they were going to transfer the medication to the sister facility. In addition, LALD/CNS-C did not have	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

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01910	Continued From page 42 documentation of the transfer of medications. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, read, "Upon disposition, We Care Home Health Services will document the following information in the clinical record a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of one of one resident (R1) when the licensee required R1 to follow certain house rules.	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02290	Continued From page 43 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on December 1, 2022, and began receiving assisted living services. R1's diagnoses included quadriplegia (paralysis caused by illness or injury that results in partial or total loss of use of all their limbs and torso), major depression, generalized anxiety disorder, asthma, hypertension, edema of the throat, and bipolar (mental disorder characterized by periods of depression and periods of abnormally elevated moods). R1's Service Plan Waiver- Addendum to Contract dated August 1, 2023, indicated R1 received assistance with activities, ambulation, lotion application, grooming, bathing, bed making, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, safety checks, and shopping assistance. R1 Resident Agreement Assisted Living signed October 14, 2022, page 11, section 17, Resident Policies, Rules, and Regulations read, "By signing this Agreement, you agree to abide by and comply with all of the Community's policies, rules and regulations, which have been provided to you in within this resident contract. The Community	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02290	Continued From page 44 reserves the right to adopt, amend and discontinue policies, rules and regulations. The Community will provide you with written notice of all such changes." On December 5, 2023, at 7:25 a.m., LALD/CNS-C provided the surveyor with a document titled House Rules / Expectations, which indicated the following: - the licensee reserves the authorization to perform random room check; - client [resident] must be home by 10:00 p.m.; - absolutely no drug use/alcohol* * zero tolerance; - no visiting in rooms of other clients [residents]; - visitation is in the common area (consult with program director if provision are needed); - no borrowing of any kind is allowed; - smoking is not allowed after 10:00 p.m.; - all meals are to be consumed in the dining area; - living room is for entertainment only, no sleeping/laying on sofa; - everyone is expected to adhere strictly to the house contract; and - no overnight visit before thirty days assessment. On December 5, 2023, at 12:23 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided the surveyor a blank contract titled Resident Agreement Assisted Living and stated it was used for all residents who resided in the assisted living. The contract page 11, section 17, Resident Policies, Rules, and Regulations read, "By signing this Agreement, you agree to abide by and comply with all of the Community's policies, rules and regulations, which have been provided to you in within this resident contract. The Community reserves the right to adopt, amend and discontinue policies, rules and regulations. The Community will provide you with written notice of all such	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02290	Continued From page 45 changes." On December 6, 2023, at 11:52 a.m., LALD/CNS-C stated with the exception of R2, who refused to sign the house rules, all other residents signed the house rules. LALD/CNS-C stated all residents were their own responsible party at the facility. In addition, LALD/CNS-C stated the residents had mental health issues and the licensee implemented the house rules to decrease behaviors and "help them." The licensee's Minnesota Home Care Bill of Rights policy dated November 2019, the policy did not address the requirements of current licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

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

Type: Full
Date: *12/04/23*
Time: 12:00:00
Report: 1013231281

Food and Beverage Establishment Inspection Report

Location:
Edinbrook Home
2000 Edinbrook Court
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037824
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122034758
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Peppers
Temperature: 15 Degrees Fahrenheit - Location: Basement freezer
Violation Issued: No

Process/Item: Cheese
Temperature: 40 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Process/Item: Sour cream
Temperature: 40 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

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

The inspection was completed with MDH J. Boettcher and the operator, then reviewed with MDH Nurse Evaluators A. Crews and D. Mosissa.

The establishment has a residential kitchen and serves food prepared that day. The kitchen has wood cabinets, linoleum floor, painted/tile walls, laminate counter top, and a textured ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize cycle.

Food and Beverage Establishment Inspection Report

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 1013231281 of 12/04/23.

Certified Food Protection Manager: Matilda Pokuaah Agyapong

Certification Number: 116139 Expires: 03/21/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Matilda Pokuaah Agyapong
Operator

Signed: JM

Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us