



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 3, 2024

Licensee
Providence Health Care Services
781 103rd Avenue Northeast
Blaine, MN 55434

RE: Project Number(s) SL40063015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on October 17, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

The total amount you are assessed is \$500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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 MDH 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.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 781 103RD AVENUE NE BLAINE, MN 55434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40063015-0 On October 15, 2024, through October 17, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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 observation, interview, and record review, the licensee failed to ensure the required staffing plan was posted in a central location as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470			

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0 470	Continued From page 2 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 15, 2024, at 11:29 a.m. until 11:39 a.m., the surveyor toured the assisted living facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and observed two weekly schedule postings dated July 22, 2024, through August 4, 2024, that indicated staff working for each shift daily. On October 16, 2024, at 10:20 a.m., LALD/CNS-A stated licensee posted a staff schedule every Monday, however, LALD/CNS-A had forgot to post the updated staffing schedule until October 16, 2024. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

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0 480	Continued From page 3	0 480			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 15, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements	0 485			

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0 485	Continued From page 4 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 485			

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0 485	Continued From page 5 During the entrance conference on October 15, 2024, at 11:06 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided residents three meals per day and the licensee did not require a resident to include and pay for meals in the resident contract that the resident did not want. On page three of the [licensee name] Resident Contract for Assisted Living, Section 4 (four): indicated all services listed on ATTACHMENT A [sic] are included in your Monthly Base Fee ("Included Services") [sic]. On Attachment A Fee Schedule - Assisted Living Facility indicated the assisted living facility offers all the following (included in the Month Base Fee) [sic] including at least three meals daily with snacks available seven (7) days per week. Resident assisted living contract addendums lacked an option for residents to opt out of payment for one, two, or all meals residents would not want. On October 16, 2024, at 10:26 a.m., LALD/CNS-A stated the licensee required residents to pay for three meals per day since all three meals were covered under the resident's insurance and LALD/CNS-A was not aware the licensee could not require residents to pay for meals residents did not want. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated September 26, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge.	0 485			

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0 485	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of one employee (unlicensed personnel (ULP)-B) during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 510			

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0 510	Continued From page 7 The findings include: On October 16, 2024, at 8:04 a.m., the surveyor observed ULP-B complete scheduled morning medication administration for R2, and ULP-B returned to the computer to document in R2's record. The surveyor did not observe ULP-B complete hand hygiene before or after medication administration for R2. On October 16, 2024, at 8:34 a.m., the surveyor observed ULP-B enter R3's room, reminded R3 to take scheduled morning medications, and returned to the computer to document in R3's record. The surveyor did not observe ULP-B complete hand hygiene before or after entering R3's room. On October 16, 2024, at 8:59 a.m., the surveyor observed ULP-B complete scheduled morning medication administration for R1. The surveyor did not observe ULP-B complete hand hygiene before or after medication administration for R1. On October 16, 2024, at 10:13 a.m., ULP-B stated ULP-B should have washed hands in between resident cares and ULP-B had received infection control training upon hire. On October 16, 2024, at 10:43 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated handwashing and infection control was the licensee's primary goal and LALD/CNS-A had trained all staff on frequent handwashing before and after resident cares. LALD/CNS-A further stated ULP-B had arrived late to work and ULP-B was nervous about the surveyor doing observations. The licensee's undated Standard Precautions for	0 510			

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0 510	Continued From page 8 All Health Care Workers indicated employees were to "WASH HANDS." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph	0 620			

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0 620	Continued From page 9 (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) after financial exploitation was alleged for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 620			

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0 620	Continued From page 10 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: During the entrance conference on October 15, 2024, at 11:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all staff at the licensee were mandated reporters, and the staff were required to make a vulnerable adult report within 24 hours of any possible neglect, abuse, or financial exploitation of a resident. R1's diagnoses included chronic obstructive pulmonary disease (COPD-difficult to breathe), depression, and atrial fibrillation (abnormal heartbeat). R1's service plan dated March 29, 2024, indicated R1's services included medication administration, assistance with bathing, grooming, and dressing, behavior monitoring, and light housekeeping. R1's (licensee's name) Health Uniform Assessment Tool dated September 29, 2024, indicated financial problems was a stressful event that affected R1's life. On October 16, 2024, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-B complete scheduled morning medication administration for R1.	0 620			

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(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
0 620	Continued From page 11 R1's record contained a Minnesota Department of Human Services (DHS) Office of Inspector General Licensing Division Incident Report and Internal Review dated October 8, 2024, at 9:29 a.m., by LALD/CNS-A and was submitted to Minnesota DHS Incident Report 245D. The incident report indicated R1 was noted to be crying in R1's room. Upon further assessment R1 stated R1 had been sending money to someone and that they (unidentified person) need additional 200 dollars, before they (unidentified person) can release R1's 10,000 dollars. LALD/CNS-A called 911, R1 was driven to the police station, R1 filled [sic] a report, and R1 was educated not to be sending money or personal information to a stranger. R1's case manager and R1's son were notified. Staff will review and assess any s/sx (signs or symptoms) of R1's financial exploitation and report to authority daily. R1's record lacked evidence of a MAARC report or phone call to MAARC for R1's suspected financial exploitation. On October 16, 2024, at 1:09 p.m., LALD/CNS-A stated LALD/CNS-A had thought the electronic medical record system used to file the incident report would forward the incident report to MAARC and LALD/CNS-A was not aware the incident report was filed with Minnesota DHS. LALD/CNS-A further stated a MAARC report should have been filed for R1's suspected financial exploitation. The licensee's undated Reporting Maltreatment of Vulnerable Adult policy indicated all facility personnel rendering service to a resident are mandated to report maltreatment or injuries which are not reasonably explained to their supervisor or to the MAARC.	0 620			

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0 620	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency	0 680			

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0 680	Continued From page 13 preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 15, 2024, at 11:29 a.m. until 11:39 a.m., the surveyor toured the assisted living facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and observed the licensee's EPP binder located at the main entrance of the facility. The licensee's EPP, dated May 20, 2023, provided to the surveyor included generic instructions for staff to follow in the case of a fire, weather, medical emergencies, and infectious disease for another assisted living facility in a different city. The licensee's EPP provided did not include the following: - a quarterly review of the missing resident policy; - a completed hazard vulnerability assessment (HVA); - policies and procedures to address natural disasters, man-made disasters, facility-based disasters, and infectious disease; - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations;	0 680			

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0 680	Continued From page 14 - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - arrangement with other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide	0 680			

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0 680	Continued From page 15 assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families; - an EP training and testing program. On October 16, 2024, at 10:40 a.m., LALD/CNS-A stated the licensee's EPP provided was for a different assisted living location owned by the licensee and LALD/CNS-A had not updated the EPP to be specific to this assisted living facility. The licensee's undated Missing Resident policy did not indicate how often the policy would be reviewed. The licensee's undated Emergency Management policy indicated the facility will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual	0 680			

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0 680	Continued From page 16 Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three resident's (R1, R2, R3) personal health and medical information was kept private. This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 700			

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0 700	Continued From page 17 The findings include: During the entrance conference on October 15, 2024, at 11:00a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. From October 15, 2024, at 12:00 p.m., through October 16, 2024, at 10:18 a.m., the surveyor observed a communication logbook containing R1, R2, and R3's names, medical information, and services received. The communication logbook was placed on a corner shelf in the upper-level dining room accessible to all residents, staff, and visitors. Throughout the survey, the surveyor observed residents go in and out of the dining room. On October 16, 2024, at 10:18 a.m., LALD/CNS-A stated the communication logbook contained private medical information on R1, R2, and R3 and the communication logbook could have potentially been accessed by any resident or visitor. LALD/CNS-A further stated the communication logbook should not have been stored in a public area of the facility. The licensee's undated Resident Records policy indicated all resident information shall be regarded as confidential and available only to authorized users. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			

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0 790	Continued From page 18	0 790			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 October 16, 2024, at 3:15 p.m., survey staff conducted a facility tour with unlicensed personnel (ULP)-B, survey staff observed that the fire extinguishers throughout the facility did not have documentation of monthly inspections.	0 790			

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0 790	Continued From page 19 Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. ULP-B stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800			

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0 800	Continued From page 20 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 October 16, 2024, at 3:15 p.m., surveyor toured the facility with unlicensed personnel (ULP)-B. The following was observed. GENERAL MAINTENANCE: Bedroom #5 carpet was soiled and had cat food and the resident's food scattered throughout. Family room in the basement had soiled carpet. Smoking Areas: It was observed that residents were smoking on the deck by the house and the cigarette butts were being put out in a small glass ashtray and then discarded in the garbage. The surveyor explained to the ULP-B, that all cigarette butts shall be properly discarded into an approved container and that cigarette smoking should take place outside in the designated area away from the structure. ULP-B stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			

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0 810	Continued From page 21	0 810			
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 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	0 810			

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0 810	Continued From page 22 review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the 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: On October 16, 2024, at 3:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency.	0 810			

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0 810	Continued From page 23	0 810			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's undated Resident Contract for Assisted Living included the following clauses that a resident would waive the facility's liability for health, safety, or personal property of the	0 970			

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0 970	Continued From page 24 resident: -page eight, Section 14 O: While you (resident) are a resident of the Community (facility) you (resident) agree to pay the Community for any loss or damage to the Apartment/Room [sic], building or grounds caused by you (resident) ... normal wear and tear expected; -page 10 Section 24. Provisions Related to Liability A. Damage of Injury to Resident of Resident's Property: We (licensee) are not responsible for any damage or injury suffered by you, your property ... that was not caused by us (licensee); and -page 10 Section 24. Provisions Related to Liability C. Resident's Responsibility for Damages: You (resident) will be responsible for (a) any loss, property damage (including plumbing problems) or cost of repairs or services caused by your (resident's) use of the Apartment/Room [sic] or the Community [sic] facilities, normal wear and tear expected; (b) any loss or damage to the Apartment/Room [sic] or Community [sic] facilities caused by doors or windows left open by you (resident) ...; (c) all costs or losses we (licensee) incur because of abandonment of the Apartment/Room [sic] or other violations of this Agreement (assisted living contract) [sic] by you (resident). On October 16, 2024, at 10:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the same contract was used for all residents. LALD/CNS-A further stated the licensee was not aware the assisted living contract could not include language waiving the facility's liability for health, safety, or personal property of a resident and the licensee had included the waivers of liability due to previous behavior from past residents at another facility.	0 970			

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0 970	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on October 15, 2024, at 11:16 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the required contents of the employee record. ULP-B was hired July 1, 2024, from a contract	01350			

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 781 103RD AVENUE NE BLAINE, MN 55434		
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01350	Continued From page 26 agency, to provide direct care services to residents at the facility. On October 16, 2024, at 8:04 a.m., the surveyor observed ULP-B complete scheduled morning medication administration for R2. ULP-B's employee record lacked the following topics required for orientation to assisted living training: -an overview of the assisted living chapter; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On October 16, 2024, at 10:37 a.m., LALD/CNS-A stated the same orientation to assisted living topics were provided to all contract agency staff upon hire. LALD/CNS-A stated the licensee was aware of all required topics to complete during orientation to assisted living, however, LALD/CNS-A forgot to assign the orientation to assisted living topics noted above to contract ULPs upon hire. The licensee's undated Facility Employee Orientation policy indicated all employees of the Assisted Living Facility [sic] shall complete orientation on topics required by Minnesota	01350			

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01350	Continued From page 27 statutes and rules for assist living and would include the following topics: -An overview of Minnesota's home care law (MN Statues 144A.43 to 144.4798); -handling of residents' complaints and reporting of complaints to the Office of Health Facility Complaints; -Consumer advocacy services of the Ombudsman for Long-Term care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates and other relevant advocacy services; and -A review of the types of services the employee will be providing and the scope of the facility's services under the specific license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640			

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01640	Continued From page 28 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a resident or resident representative's signature to document agreement on the services to be provided for one of two residents (R2). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on October 15, 2024, at 11:00a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. On October 16, 2024, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-B complete scheduled morning medication administration to R2.	01640			

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01640	Continued From page 29 R2's service plan dated October 1, 2024, indicated R2's services included assistance with bathing, grooming, dressing, medication administration, and oxygen management. R2's service plan lacked a resident or resident representative signature to document agreement on the services to be provided. On October 16, 2024, at 1:22 p.m., LALD/CNS-A stated resident service plans are signed upon admission, however, R2's service plan was missing R2's signature due to R2 being on the phone with R2's daughter. The licensee's undated Service Plan policy indicated the service plan and any revisions must include a signature by the resident or the resident's representative documenting the agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730			

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01730	Continued From page 30 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of two residents (R2).	01730			

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01730	Continued From page 31 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: During the entrance conference on October 15, 2024, at 11:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD- difficult to breathe), hypertension (HTN- high blood pressure), and diabetes. R2's service plan dated October 1, 2024, indicated R2's services included medication administration four times daily and as needed (PRN). R2's prescriber orders dated October 1, 2024, included an order for Dulera 200-5 micrograms (mcg)/actuation inhale two puffs by mouth two times daily. R2's electronic medication administration record (EMAR) dated October 2024, indicated Dulera 200 mcg-5 mcg administer two puffs twice daily. On October 16, 2024, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-B complete	01730			

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01730	Continued From page 32 a scheduled morning medication administration for R2. ULP-B handed R2 the Dulera inhaler for self-administration, R2 inhaled two puffs, and R2 returned the Dulera inhaler to ULP-B. ULP-B handed R2's oral medications to R2, R2 took the morning medications with water, and swallowed the water. On October 16, 2024, at 12:27 p.m., ULP-B stated ULP-B did not offer for R2 to rinse R2's mouth after R2 completed administering the Dulera inhaler. ULP-B further stated R2's EMAR did not instruct to have R2 rinse R2's mouth after the Dulera administration. R2's Medication Assessment and Management Plan dated October 1, 2024, indicated all medications were administered as prescribed or ordered were located on R2's EMAR, however, R2's EMAR lacked specific resident instructions for R2 to rinse out R2's mouth after R2 was administered R2's Dulera inhaler. On October 16, 2024, at 1:20 p.m., LALD/CNS-A stated ULPs were trained to offer residents to rinse out the resident's mouth after administration of an inhaler that contained a steroid and ULPs were trained to refer to the EMAR for any instructions during the medication administration. The manufacturer's instructions for use of Dulera inhaler dated April 2015, indicated to rinse mouth with water after use. The licensee's undated Documentation of Medication policy indicated staff will administer the medication according to the instructions on the MAR (medication administration record). No further information was provided.	01730			

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01730	Continued From page 33	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-B) observed administering medications for one of two residents (R2). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01760			

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01760	Continued From page 34 The findings include: During the entrance conference on October 15, 2024, at 11:05 a.m., licensed assisted living director/clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD- difficult to breathe), hypertension (HTN- high blood pressure), and diabetes. R2's service plan dated October 1, 2024, indicated R2's services included medication administration four times daily and as needed (PRN). R2's prescriber orders dated October 1, 2024, included an order for Dulera 200-5 micrograms (mcg)/actuation inhale two puffs by mouth two times daily. R2's electronic medication administration record (EMAR) dated October 2024, indicated Dulera 200 mcg-5mcg administer two puffs twice daily. ULP-B's employee record contained a Skills Competency Inhaler Administration dated August 1, 2024, which indicated ULP-B had passed competency of inhaler administration, and the competency included having the resident rinse out their mouth after each inhaler use. On October 16, 2024, at 8:04 a.m., the surveyor observed ULP-B complete a scheduled morning medication administration for R2. ULP-B handed R2 the Dulera inhaler for self-administration, R2 inhaled two puffs, and R2 returned the Dulera	01760			

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01760	Continued From page 35 inhaler to ULP-B. ULP-B handed R2's oral medications to R2, R2 took the morning medications with water, and swallowed the water. On October 16, 2024, at 12:27 p.m., ULP-B stated ULP-B did not offer for R2 to rinse R2's mouth after R2 completed administering the Dulera inhaler. ULP-B further stated R2's EMAR did not instruct to have R2 rinse R2's mouth after the Dulera administration. On October 16, 2024, at 1:20 p.m., LALD/CNS-A stated ULPs were trained to offer residents to rinse out the resident's mouth after administration of an inhaler that contained a steroid and ULPs were trained to refer to the EMAR for any instructions during the medication administration. The manufacturer's instructions for use of Dulera inhaler dated April 2015, indicated to rinse mouth with water after use. The licensee's undated Documentation of Medication policy indicated staff will administer the medication according to the instructions on the MAR (medication administration record). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for	01790			

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01790	Continued From page 36 the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;	01790			

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01790	Continued From page 37 (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure one of one ULP (ULP-B) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01790			

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01790	Continued From page 38 During the entrance conference on October 15, 2024, at 11:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. UNPLANNED TIME AWAY POLICY AND PROCEDURE FOR ULP The licensee's undated Medications for a Resident Who Will Be Away from a Facility When Medications Are Scheduled policy indicated for unplanned resident time away when a pharmacy or licensed nurse is not available, the RN may delegate this task to the ULP if the RN has trained the ULP and determined the ULP to be competent to follow the procedures for giving medications to residents. The RN needs to have developed written procedures for the ULPs, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The licensee's policy lacked written procedures to include the following: -the type of container to be used for the medications appropriate to the facility's medication system; -how the container must be labeled; and -how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medications and the doses of each medication returned. TRAINING AND COMPETENCY EVALUATIONS ULP-B was hired July 1, 2024, from a contract agency, to provide direct care services to residents at the facility, which included medication	01790			

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE SERVICE		STREET ADDRESS, CITY, STATE, ZIP CODE 781 103RD AVENUE NE BLAINE, MN 55434			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01790	Continued From page 39 administration. On October 16, 2024, at 8:04 a.m., the surveyor observed ULP-B complete scheduled morning medication administration for R2. ULP-B's employee record lacked evidence to indicate ULP-B had been trained and had demonstrated competency to provide medications to residents for unplanned times away from the facility. On October 16, 2024, at 1:24 p.m., LALD/CNS-A stated the licensee's unplanned time away policy for residents did not have specific instructions for the ULP to follow. LALD/CNS-A further stated LALD/CNS-A had not trained ULPs on unplanned time away since LALD/CNS-A lived near the facility and LALD/CNS-A could come to the facility to set up medications for a resident who would have unplanned time away. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=F	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 ensure one of one	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 781 103RD AVENUE NE BLAINE, MN 55434		
(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
01880	Continued From page 40 refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. 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: During the entrance conference on October 15, 2024, at 11:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. On October 16, 2024, at 9:24 a.m., LALD/CNS-A stated the current temperature of the locked medication refrigerator located in the office was 30 degrees Fahrenheit (F) and contained the following medications: -two unopened brimonidine tartrate 0.15% bottles for R3 -one unopened dorzolamide-timolol 2%-0.5% bottle for R3 -four unopened latanoprost 0.005% bottles for R3 -three unopened Ozempic 0.5 milligrams (mg) pens for R3 The licensee's Refrigerator Temperature Logs-Medication Fridge dated September 2024, and October 2024, respectively, indicated the medication refrigerator temperature was checked	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 781 103RD AVENUE NE BLAINE, MN 55434		
(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
01880	Continued From page 41 twice daily with a reading of 32 degrees F, however, on October 9, 2024, at 9:00 a.m., the medication refrigerator temperature was 31 degrees F. On October 16, 2024, at 10:20 a.m., LALD/CNS-A stated the medication refrigerator temperature was checked two times per day and typically the medication refrigerator temperature was to be kept between 30 degrees F to 32 degrees F. LALD/CNS-A further stated the licensee was not aware the manufacturer's instructions for storing medications in the refrigerator was typically 36 degrees F to 46 degrees F. The manufacturer's instructions for brimonidine tartrate dated March 2016, indicated to store brimonidine tartrate between 59 degrees F to 77 degrees F. The manufacturer's instructions for dorzolamide-timolol dated October 2009, indicated to store dorzolamide-timolol at room temperature between 59 degrees F to 86 degrees F. The manufacturer's instructions for latanoprost ophthalmic solution dated September 2020, indicated to store unopened latanoprost bottles in the refrigerator at 36 degrees F to 46 degrees F. The manufacturer's instructions for Ozempic dated October 2022, indicated to store unopened Ozempic in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Ozempic to freeze. The licensee's undated Individualized Medication Management Plan and Record policy indicated the individualized medication management plan	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 781 103RD AVENUE NE BLAINE, MN 55434		
(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
01880	Continued From page 42 would include a description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	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 medications were maintained with the original prescription label for one of three 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: During the entrance conference on October 15,	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE SERVICE		STREET ADDRESS, CITY, STATE, ZIP CODE 781 103RD AVENUE NE BLAINE, MN 55434			
(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
01890	Continued From page 43 2024, at 11:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. On October 16, 2024, at 9:22 a.m., the surveyor reviewed the locked medication file cabinet with unlicensed personnel (ULP)-B and observed R2's Dulera 200 micrograms (mcg)- 5 mcg inhaler was not labeled with a prescription label. ULP-B stated R2's Dulera inhaler use to be stored in the box with the original prescription label, however, the Dulera box may have been thrown away. On October 16, 2024, at 10:45 a.m., LALD/CNS-A stated all medications, including inhalers, should be stored with the pharmacy prescription label, however, R2's Dulera inhaler box with the original prescription label may have been misplaced or lost when R2 took the Dulera Inhaler out of the facility. The licensee's undated Medication Prescriptions and Refills policy indicated the resident's individualized medication management plan will reflect the method of reordering, delivery, storage [sic] and security, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Type: Follow-Up
Date: 11/08/24
Time: 09:15:34
Report: 1029241396

Food and Beverage Establishment Inspection Report

Page 1

Location:

PROVIDENCE HEALTH CARE SERVICE
781 103RD AVENUE NE
Blaine, MN55434
Anoka County, 02

Establishment Info:

ID #: 0043720
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders previously issued on 10/15/24 have NOT been corrected.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

PHOTOCOPY OF CFPM CERTIFICATE POSTED. REP INSTRUCTED TO HAVE THE ORIGINAL PRINTED ON SECURITY PAPER POSTED.

10/28/24: REPEAT.

11/8/24: ESTABLISHMENT HAS SUBMITTED A REQUEST FOR A DUPLICATE CFPM CERTIFICATE.

Issued on: 10/15/24

Comply By: 10/15/24

No NEW orders were issued during this inspection.

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

Type: Follow-Up
Date: 11/08/24
Time: 09:15:34
Report: 1029241396
PROVIDENCE HEALTH CARE SERVICE

Food and Beverage Establishment Inspection Report

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 1029241396 of 11/08/24.

Certified Food Protection Manager; JAMEELAH T. NANCE

Certification Number: FM119532 Expires: 09/21/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
JARED KENYANA
RN

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Type: Follow-Up
Date: 10/28/24
Time: 11:18:14
Report: 1029241377

Food and Beverage Establishment Inspection Report

Page 1

Location:

PROVIDENCE HEALTH CARE SERVICE
781 103RD AVENUE NE
Blaine, MN55434
Anoka County, 02

Establishment Info:

ID #: 0043720
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders previously issued on 10/15/24 have NOT been corrected.

3-500B Microbial Control: hot and cold holding

3-501.16A2 **** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

SEVERAL TCS ITEMS IN LOWER PART OF REFRIGERATOR IN DANGER ZONE. ITEMS DISCARDED AND COOLER ADJUSTED.

10/28/24: REPEAT.

Issued on: 10/15/24

Comply By: 10/15/24

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO THERMAL STICKERS OR MIN/MAX THERMOMETER. 1 THERMAL STICKER PROVIDED TO VERIFY DISHWASHER HIGH TEMP. REP INSTRUCTED TO OBTAIN MEANS TO TEST HIGH TEMP IN DISHWASHER.

10/28/24: REPEAT.

Issued on: 10/15/24

Comply By: 10/18/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

PHOTOCOPY OF CFPM CERTIFICATE POSTED. REP INSTRUCTED TO HAVE THE ORIGINAL PRINTED ON SECURITY PAPER POSTED.

10/28/24: REPEAT.

Type: Follow-Up
Date: 10/28/24
Time: 11:18:14
Report: 1029241377
PROVIDENCE HEALTH CARE SERVICE

Food and Beverage Establishment Inspection Report

Issued on: 10/15/24 Comply By: 10/15/24

The following orders were issued during this inspection.

4-200 Equipment Design and Construction
4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

MEATBALLS IN SAUCE, NOODLES, AND COOKED RICE BEING PREPARED IN ESTABLISHMENT AND HELD IN REFRIGERATOR FOR SEVERAL DAYS. REP INSTRUCTED TO HAVE SAME-DAY SERVICE FOR COMBINED TCS ITEMS.

Comply By: 10/28/24

Food and Equipment Temperatures

Process/Item: COLD HOLD/MILK
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR - TOP AREA
Violation Issued: No

Process/Item: COLD HOLD/ALMOND MILK
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR - TOP AREA
Violation Issued: No

Process/Item: COLD HOLD/MEATBALLS
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR - TOP AREA
Violation Issued: No

Process/Item: COLD HOLD/CREAMER
Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: Yes

Process/Item: COLD HOLD/BACON
Temperature: 43 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER AREA
Violation Issued: Yes

Process/Item: COLD HOLD/SHREDDED CHEESE
Temperature: 44 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER AREA
Violation Issued: Yes

Process/Item: COLD HOLD/LETTUCE
Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER AREA
Violation Issued: Yes

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

Temperature abused items again identified in lower areas of refrigerator and discarded by establishment representative. Representative instructed to only use the upper areas of the interior cavity to cold hold TCS foods and to repair or replace the cooler so that it keeps safe temperature throughout the cooler. Operator indicated over the phone that the establishment would have a new refrigerator installed on November 1st.

Type: Follow-Up
Date: 10/28/24
Time: 11:18:14
Report: 1029241377

Food and Beverage Establishment Inspection Report

Page 3

PROVIDENCE HEALTH CARE SERVICE

Same-day service, cold holding, and food safety discussed in person with staff and over the phone with the operators.

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 1029241377 of 10/28/24.

Certified Food Protection Manager: JAMEELAH T. NANCE

Certification Number: FM119532 Expires: 09/21/26

Inspection report reviewed with person in charge and emailed.

Signed: 
BODE OSARO
CNA

Signed: 
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Type: Full
Date: 10/15/24
Time: 13:03:37
Report: 1029241359

Food and Beverage Establishment Inspection Report

Page 1

Location:

PROVIDENCE HEALTH CARE SERVICE
781 103RD AVENUE NE
Blaine, MN55434
Anoka County, 02

Establishment Info:

ID #: 0043720
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2

**** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

SEVERAL TCS ITEMS IN LOWER PART OF REFRIGERATOR IN DANGER ZONE. REP ADJUSTED REFRIGERATOR FROM 3 TO 5 AND DISCARDED TEMP ABUSED ITEMS. REP INSTRUCTED TO VERIFY SAFE TEMP THROUGHOUT COOLER PRIOR TO PLACING ADDITIONAL TCS ITEMS INTO COOLER.

Comply By: 10/15/24

3-500C Microbial Control: date marking

3-501.17B

**** Priority 2 ****

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

SEVERAL OPEN PACKAGES OF DELI MEATS AND SHREDDED CHEESES W/OUT DATE MARKINGS AND SEVERAL UNOPENED TCS ITEMS BEYOND USE-BY-DATE. ITEMS DISCARDED BY REP. REP INSTRUCTED TO DATE MARK REQUIRED ITEMS AND NOT PROVIDE FOODS TO CLIENTS BEYOND USE-BY-DATE.

Comply By: 10/15/24

Type: Full
Date: 10/15/24
Time: 13:03:37
Report: 1029241359
PROVIDENCE HEALTH CARE SERVICE

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
NO THERMAL STICKERS OR MIN/MAX THERMOMETER. 1 THERMAL STICKER PROVIDED TO VERIFY DISHWASHER HIGH TEMP. REP INSTRUCTED TO OBTAIN MEANS TO TEST HIGH TEMP IN DISHWASHER.
Comply By: 10/18/24

6-300 Physical Facility Numbers and Capacities

6-301.12 **** Priority 2 ****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
PAPER TOWELS NOT AT HANDWASHING SINK. CORRECTED DURING INSPECTION.
Comply By: 10/15/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.
PHOTOCOPY OF CFPM CERTIFICATE POSTED. REP INSTRUCTED TO HAVE THE ORIGINAL PRINTED ON SECURITY PAPER POSTED.
Comply By: 10/15/24

Surface and Equipment Sanitizers

HOT WATER: = at >150 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COOK TEMP/CHICKEN
Temperature: 167 Degrees Fahrenheit - Location: COOK TEMP - OUT OF POT
Violation Issued: No

Process/Item: COOK TEMP/CHICKEN
Temperature: 175 Degrees Fahrenheit - Location: COOK TEMP - OUT OF POT
Violation Issued: No

Process/Item: COOK TEMP/RICE
Temperature: 189 Degrees Fahrenheit - Location: COOK TEMP - OUT OF POT
Violation Issued: No

Process/Item: COLD HOLD/ALMOND MILK
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR - TOP
Violation Issued: No

Type: Full
Date: 10/15/24
Time: 13:03:37
Report: 1029241359

Food and Beverage Establishment Inspection Report

PROVIDENCE HEALTH CARE SERVICE

Process/Item: COLD HOLD/HEAVY CREAM
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR - TOP
Violation Issued: No

Process/Item: COLD HOLD/SLICED TURKEY
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

Process/Item: COLD HOLD/DELI MEAT
Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

Process/Item: COLD HOLD/DELI MEAT
Temperature: 51 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

Process/Item: COLD HOLD/SLICED CHEESE
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

Process/Item: COLD HOLD/POTATO SALAD
Temperature: 42 Degrees Fahrenheit - Location: REFRIGERATOR - UPPER
Violation Issued: No

Process/Item: COLD HOLD/CREAM CHEESE
Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

Process/Item: COLD HOLD/SOUR CREAM
Temperature: 47 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: Yes

Process/Item: COLD HOLD/SOUR CREAM
Temperature: 51 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: Yes

Process/Item: COLD HOLD/BUTTER
Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

Process/Item: COLD HOLD/SLICED CHEESE
Temperature: 47 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

Process/Item: COLD HOLD/SHELL EGG
Temperature: 49 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

Process/Item: COLD HOLD/SHELL EGG
Temperature: 48 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

Process/Item: COLD HOLD/DAIRY CREAMER
Temperature: 50 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: Yes

Type: Full
Date: 10/15/24
Time: 13:03:37
Report: 1029241359
PROVIDENCE HEALTH CARE SERVICE

Food and Beverage Establishment
Inspection Report

Process/Item: COLD HOLD/BUTTER
Temperature: 47 Degrees Fahrenheit - Location: REFRIGERATOR - LOWER
Violation Issued: Yes

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

Kitchen has pergo-esque flooring, wood/composite wood drawers and cabinetry with laminate, mdf laminate countertops, and smooth painted walls and ceiling. Establishment uses dishwasher to sanitize equipment and utensils.

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 1029241359 of 10/15/24.

Certified Food Protection Manager: JAMEELAH T. NANCE

Certification Number: FM119532 Expires: 09/21/26

Inspection report reviewed with person in charge and emailed.

Signed: JARED KENYANYA
RN

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241359

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, and Lodging Services

625 Robert Street North

St. Paul

No. of RF/PHI Categories Out

4

Date

10/15/24

No. of Repeat RF/PHI Categories Out

0

Time In

13:03:37

Legal Authority MN Rules Chapter 4626

Time Out

PROVIDENCE HEALTH CARE...

Address

781 103RD AVENUE NE

City/State

Blaine, MN

Zip Code

55434

Telephone

License/Permit #

0043720

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate procedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labeled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date: 10/16/24

Inspector (Signature)

Trevor McCliment