



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 12, 2024

Licensee

Metropolitan Sincerity Hc
2748 Chicago Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL34883015

Dear Licensee:

On March 28, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 10, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Robert Dehler', with a horizontal line extending from the end.

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/28/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34883015-1 On March 27, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 10, 2024. At the time of the survey, there were 6 residents; 6 receiving services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}			
{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: No further action needed.	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/28/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
{0 680}	Continued From page 1	{0 680}			
{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: No further action needed.	{0 680}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/28/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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	
{01620}	Continued From page 2 reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action needed.	{01620}			
{01760} SS=F	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	{01760}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/28/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
{01760}	Continued From page 3 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: No further action needed.	{01760}			
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01820}			
{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: No further action needed.	{01890}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by	{01910}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/28/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
{01910}	Continued From page 4 the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action needed.	{01910}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 6, 2024

Licensee

Metropolitan Sincerity HC
2748 Chicago Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL34883015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 10, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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 black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" written in a larger, more prominent script than the last name "DeVries".

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34883015-0 On January 8, 2024, through January 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, all of whom were receiving services under the Assisted Living 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
0 480	Continued From page 1 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 had the potential to affect all residents of the assisted living 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR), dated January 8, 2024, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
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	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
0 680	Continued From page 2 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 and update annually, a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
0 680	Continued From page 3 The findings include: The licensee's undated EP plan lacked documentation the plan was reviewed annually. The plan further lacked the following: - a tracking system used to document locations of residents and staff; - a communication plan that included names and contact information for staff, resident physicians, other facilities; - documentation the licensee conducted exercises to test the EP at least twice per year, including unannounced staff drills using the EP. On January 9, 2024, at 4:03 p.m., licensed assisted living director (LALD)-A stated they tried to follow an outline provided by their consultant, but did not totally understand all the requirements so might have missed some things. LALD-A further stated they had not participated in any full-scale or tabletop emergency exercise, and he was not aware of that requirement. The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated, "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." The policy further indicated, "The emergency preparedness plan/program will be reviewed/updated at least annually." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
0 780	Continued From page 4 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and 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, but was not likely to	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
0 780	Continued From page 5 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 8, 2024, at 1:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-C. During the tour, it was observed upon testing, the smoke alarms in the facility were not interconnected, so the actuation of one smoke alarm would cause all other alarms in the facility to actuate. On January 8, 2024, at 1:00 p.m., LALD-A confirmed the licensee installed smoke alarms in the resident's sleeping rooms and the immediate vicinity of sleeping rooms, but the smoke alarms were not interconnected to each other. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
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	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 790	Continued From page 6 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers and failed to provide adequately rated (size) portable fire extinguishers as required for the facility. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 8, 2024, at 1:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-C. During the tour, it was observed the fire extinguishers on all three floors did not have a service tag showing they had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. It was also observed the installed fire extinguishers on all floors were 1-A:10-BC (size) rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required.	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 790	Continued From page 7 On January 8, 2024, at 1:00 p.m., LALD-A verified that maintenance had not been completed as required and the facility did not have an appropriate size fire extinguisher. 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 in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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).	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
0 800	Continued From page 8 The findings include: On January 8, 2024, at 1:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-C. Inside the shed in the backyard, it was observed burnt used cigarettes were tossed on the wood platform and ground, and being disposed of without a proper disposal container, creating a possible fire hazard. In the bathroom on the first floor, it was observed there was a large hole in the wall next to toilet. On January 8, 2024, at 1:00 p.m., LALD-A verified the backyard shed is where residents smoke, but there was no fire-safe disposal container for smoking residents in the shed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 9 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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 10 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 8, 2024, at 3:00 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP did not show the location and number of resident rooms. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP also instructed staff to close all doors to contain the fire, but the facility did not have a fire rated door and wall assembly. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 11 specific layout in the event of a fire or similar emergency. During interview on January 8, 2024, at 3:00 p.m., LALD-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. And also, CNS-B stated the facility was in communication with another facility to use them as an emergency relocation site. LALD-A verified the facility needed to update the fire safety and evacuation plan with the location and number of resident rooms. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on January 8, 2024, at 3:00 p.m., LALD-A stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD-A confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. DRILLS Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift as required by statute. Provided documentation indicated drills were conducted for the first and second shifts, and the facility failed to provide two drills for the third shift. During the interview on January 8, 2024, at 3:00 p.m., LALD-A stated drills were conducted in the	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 12 morning and afternoon and confirmed that the facility did conduct two drills for the night shift. LALD-A verified there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected the unoccupied resident bedrooms #6 on the attic floor. This practice resulted in a level two violation (a	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
0 820	Continued From page 13 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: On January 8, 2024, at 1:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-C. During the facility tour, survey staff observed the following items: It was observed unoccupied resident bedroom #6 on the attic floor did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16 inches in height and 24.5 inches in width, with a total openable area of 392 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On January 8, 2024, at 1:00 p.m., survey staff explained to LALD-A at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings.	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
0 820	Continued From page 14	0 820			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R2, R3).	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
01620	Continued From page 15 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: R2 R2's Service Plan, dated April 8, 2021, indicated services provided were as listed in the care plan. R2's Home Health Aide Care Plan, dated March 20, 2021, indicated R2 had diagnoses including schizophrenia, diabetes, bipolar disorder, major depression, asthma, and anxiety. The care plan indicated R2 received services including assistance with dressing, blood glucose monitoring, and medication management. R2's record included a comprehensive nursing assessment dated June 24, 2023, and subsequent assessments dated September 25, 2023, 93 days after the previous assessment, and December 26, 2023, 92 days after the previous assessment. R3 R3's Service Plan, dated October 20, 2023, indicated services provided as listed in the care plan. R3's Home Health Aide Care Plan, dated October 20, 2023, indicated R3 had diagnoses including schizophrenia, anxiety, and depression. The care plan indicated R3 received services including	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
01620	Continued From page 16 assistance with dressing, grooming, meals, behavior management, blood glucose monitoring, and medication management. R3's record included a comprehensive nursing assessment dated June 8, 2023, and subsequent assessments dated September 9, 2023, 93 days after the previous assessment, and December 10, 2023, 92 days after the previous assessment. On January 9, 2024, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated she was counting by 3 months rather than 90 days. CNS-B stated all resident assessments were scheduled that way, so many others would likely be a day or two after 90 days, as well. The licensee's Assessment and Reassessment policy, dated August 1, 2021, indicated, "Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01760 SS=F	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	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
01760	Continued From page 17 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 medications were administered per physician's orders for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2 R2's Service Plan, dated April 8, 2021, indicated services provided were as listed in the care plan. R2's Home Health Aide Care Plan, dated March 20, 2021, indicated R2 had diagnoses including schizophrenia, diabetes, bipolar disorder, major depression, asthma, and anxiety. The care plan indicated R2 received services including assistance with dressing, blood glucose monitoring, and medication management. R2's electronic medication administration record (eMAR) for January 2024, indicated medications available included:	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
01760	Continued From page 18 -cetirizine hydrochloride (for allergies), 10mg, 9:00 a.m.; -metformin hydrochloride (for diabetes) 500mg 4 tablets, 9:00 a.m.; -risperidone (for schizophrenia) 2 mg, 9:00 a.m., and 3 mg, 9:00 p.m.; -olanzapine (for schizophrenia) 10 mg, 9:00 p.m.; -sertraline (antidepressant) 50 mg, 2 tablets, 9:00 p.m.; and -trazadone (antidepressant) 100 mg, 2 tablets, 9:00 p.m. The eMAR for January 2024 further indicated the following medication was available as needed, but was not documented as administered: -fluticasone propionate (a steroid medication for asthma) nasal spray, spray into each nostril as needed for allergies. R2's record included signed orders dated December 19, 2023. The orders included: -gabapentin (for nerve pain) 300 mg, take one capsule (300 mg) three times daily, whereas R2's eMAR for January 1-7, 2024, did not include gabapentin; -risperidone 1 mg, take one tablet (1 mg) by mouth at bedtime, whereas the eMAR indicated 2 mg daily at 9:00 a.m., and 3 mg daily at 9:00 p.m.; -sertraline 50 mg, take three tablets (150 mg) by mouth daily, whereas the eMAR indicated 2 tablets (100 mg) at 9:00 p.m.; -fluticasone propionate 50 micrograms (mcg), use two sprays in each nostril once daily, whereas the eMAR indicated as needed (and not administered in December or January); and -olanzapine half tablet 5 mg by mouth as needed, whereas the eMAR only included a scheduled dose, and lacked an "as needed" dose of olanzapine.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
01760	Continued From page 19 R3 R3's Service Plan, dated October 20, 2023, indicated services provided as listed in the care plan. R3's Home Health Aide Care Plan, dated October 20, 2023, indicated R3 had diagnoses including schizophrenia, anxiety, and depression. The care plan indicated R3 received services including assistance with dressing, grooming, meals, behavior management, blood glucose monitoring, and medication management. On January 9, 2024, the surveyor observed unlicensed personnel (ULP)-C administer medications to R3. ULP-C documented the medication administration in the eMAR. R3's eMAR for January 2024 indicated medications available included: -atorvastatin 40 mg, 9:00 a.m.; and -metformin 1000 mg, 9:00 a.m., 9:00 p.m. R3's record included a signed order dated April 6, 2023. The order included the following: -metformin 500mg, "take 4 tablets (2000 mg) daily", whereas R3's eMAR instead indicated, "Metformin tab 1000 mg (Daily), Take 4 tablets (2000 mg) by mouth twice daily"; and -"atorvastatin 20 mg tablet, Take 1 tablet (20 mg) by mouth daily", whereas R3's eMAR indicated 40 mg daily. On January 9, 2024, at 9:20 a.m., ULP-C stated R3 was previously taking four 500mg pills, but she did not want to take so many pills, so the order was changed to 1000 mg pills, per her request. R3 nodded in agreement with the statement. Clinical nurse supervisor (CNS)-B agreed and stated the medication administration	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
01760	Continued From page 20 record (MAR) needed to be updated. On January 9, 2024, at 11:26 a.m., CNS-B stated R2 had a lot of medication changes recently, and all might not be updated in the eMAR. CNS-B stated updating the MAR with medication changes was her role, and she knew they had all of the orders and documentation of medication changes, but could not find them at that time. -at 11:50 a.m., CNS-B stated R2's gabapentin and fluticasone were on hold. CNS-B stated she had a verbal order, but it was not documented. On January 10, at 9:26 a.m., licensed assisted living director (LALD)-A stated he was trained in the electronic documentation system, and entered the medications into the eMAR without CNS-B's knowledge. LALD-A stated he was using the eMAR to train his staff, while CNS-B had directed staff to continue to use paper for documentation. On January 11, 2024, at 7:33 a.m., CNS-B stated via email that there was a binder that included the paper MAR, but staff must have misplaced it, and she did not have time to look for it "yesterday" (January 10, 2024). On January 11, 2024, at 8:14 a.m., CNS-B stated via phone that she did not approve use of the eMAR because she was not yet trained on the electronic record system. CNS-B stated the eMAR was not the official documentation record, and she instructed staff to continue to document on a paper MAR. CNS-B then stated staff were instructed to document on both the paper MAR and the eMAR until she could become more familiar with the system. CNS-B stated she did not know why ULP-C documented only in the eMAR during the survey, and that the paper MAR	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
01760	Continued From page 21 was in a binder that must have been misplaced. The surveyor requested R2 and R3's paper MAR. The licensee provided R2 and R3's paper MAR for December 2023 and January 2024 via email on January 12, 2024, at 7:48 a.m., after the survey exit. The MARs lacked authentication to identify the staff whose initials were entered to document medication administration. The paper MAR included several additional documentation and transcription errors: R2 and R3's paper MAR for December 2023 and January 2024 lacked indication of any medication refusals, whereas the eMAR indicated R2 refused medications December 1,3,8-10, 12, 15, 17-21, 23, 25, 29-31, and January 6 and 7, and R3 refused medications December 1, 11, and 29, 2023, with reasons documented in the notes. R2's paper MAR indicated: -cetirizine Hcl: 10 mg Tabs. Take 1 tablet (10 mg) by mouth daily, administered twice daily at 9:00 a.m. and 9:00 p.m., which differed from the signed order that indicated 10 mg, "Take 1 tablet (10 mg) by mouth daily"; -risperidone: 1 mg, Take 1 tablet (1 mg) by mouth at bedtime, discontinued as of December 21, 2023, which differed from the order signed December 19 that indicated 1 tablet (1 mg) by mouth at bedtime; -sertraline 100 mg tab, take two tablets (200 mg) by mouth at bedtime, and sertraline 50 mg tab, take three tablets (150 mg) by mouth at bedtime, which differed from the signed order that indicated 50 mg, take three tablets (150 mg) by mouth daily. The MAR further included an entry indicating, "HALF tablet (5 mg) by mouth as needed. Mood swings/agitation/psychosis/anxiety" The entry	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
01760	Continued From page 22 lacked a medication name, although the remaining information matched the order for olanzapine, as needed. R3's paper MAR indicated: -"metformin 1000 mg tab. Take 1 tab in the morning and 1 tab in the evening", which differed from the signed order that indicated, metformin 500 mg, "take 4 tablets (2000 mg) daily"; -"atorvastatin 40 mg tab. Take one tablet by mouth daily", which differed from the signed order that indicated, "atorvastatin 20 mg tablet, Take 1 tablet (20 mg) by mouth daily". The licensee's Medication Documentation policy, dated August 1, 2021, indicated, "Each medication administered by [licensee] staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible. Residents' needs will be met related to the Medication Management Plan." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
01820	Continued From page 23 electronically recorded prescriptions were obtained for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 R3's Service Plan, dated October 20, 2023, indicated services provided as listed in the care plan. R3's Home Health Aide Care Plan, dated October 20, 2023, indicated R3 had diagnoses including schizophrenia, anxiety, and depression. The care plan indicated R3 received services including assistance with dressing, grooming, meals, behavior management, blood glucose monitoring, and medication management. On January 9, 2024, the surveyor observed unlicensed personnel (ULP)-C administer medications to R3. R3's electronic medication administration record (eMAR) for January 2024, indicated the following medications were administered, or were available to be administered January 1-9, 2024: -ofloxacin drops (for bacterial infections)0.3% ophthalmic; -prednisolone suspension (a steroid) 1% ophthalmic; -aspirin 81 milligrams (mg), one tablet by mouth	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
01820	Continued From page 24 (PO) daily; -olanzapine (antipsychotic) 10 mg, one tablet PO daily at bedtime; and -quetiapine (antipsychotic) 400 mg, one tablet PO at bedtime. On January 9, 2024, at 11:26 a.m., clinical nurse supervisor (CNS)-B stated updating the MAR with medication changes was her role, and she knew they had all of the orders and documentation of medication changes, but could not find them at that time. On January 9, 2024, at 2:13 p.m. ULP-C stated R3 was not currently taking the eye drops (ofloxacin and prednisolone), because her doctor did not want her taking them until after an upcoming procedure. ULP-C stated the doctor would start R3 on new prescription after the procedure. R3's record included an additional medication administration record (MAR), documented on paper, and provided after survey exit, that indicated ofloxacin drops 0.3% ophthalmic, and prednisolone suspension 1% ophthalmic were administered to the right eye, four times daily, January 1-11, 2024. R3's record lacked current signed orders for the above-listed medications. On January 11, 2024, at 8:14 a.m., CNS-B stated via phone that the eMAR was not approved for use by her because she was not yet trained on the electronic record system. CNS-B stated she instructed staff to continue to document on paper, and that the paper MAR was in a binder that must have been misplaced. The paper MAR was provided via email January 12, 2024, at 7:48	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
01820	Continued From page 25 a.m., after the survey exit. The licensee provided orders for the above medications, signed January 10, 2024, (after the start of the survey). The orders were provided via email January 12, 2024, at 7:48 a.m., after the survey exit. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated, "Written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications." The policy further indicated, "All orders must be signed and dated by the prescriber. If the prescriber omitted a date, the facility will date the order when received from the prescriber." The policy further indicated, "The Registered Nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional", and "Medication and treatment orders will be renewed at least every year or when changes occur." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
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.	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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 26 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained including the opened date for time sensitive medication storage for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's Home Health Aide Care Plan, dated March 20, 2021, indicated R2 received services including assistance with medication management and blood glucose monitoring. R2's medication administration record for January 2024, indicated R2 received assistance with medication administration including Novolog (insulin aspart, a fast-acting insulin), 9:00 a.m., and 9:00 p.m. daily, January 1-7, 2024. On January 8, 2024, at 12:08 p.m., during a facility tour, the surveyor observed the medication refrigerator with unlicensed personnel (ULP)-C. The refrigerator contained six Novolog insulin pens. The pens lacked a label identifying which resident they belonged to. One pen did not have a cap, but appeared full. Another pen was open and partially used. Both pens lacked a date to indicate when they were opened. ULP-C stated	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC			STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 27 the pens belonged to R2. ULP-C stated he did not write opened dates on the insulin pens because R2 used the insulin quickly, before it would expire. On January 8, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)-B stated the box of insulin pens did not fit in the small refrigerator, so they took them out of the box. CNS-B stated R2 was the only resident taking insulin, so they knew the medication belonged to him. CNS-B stated the empty box was kept in the medication cart, so staff could refer to the prescription label when administering the medication. The surveyor requested to view the box, but it was not provided. CNS-B further stated she thought staff were trained to date the insulin pens when first used. - at 12:33 p.m., CNS-B stated they must have discarded the insulin box bearing the prescription label. Manufacturer directions for Novolog flex pen, dated October 2021, indicated opened pens should be stored at room temperature (up to 86°F or 30°C), and discarded after 28 days. The directions indicated unopened pens stored in a refrigerator (36°F to 46°F or 2°C to 8°C), were good until the printed expiration date. The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated, "The licensed nurse is responsible for dating time-sensitive medications when opened." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
01910	Continued From page 28	01910			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER METROPOLITAN SINCERITY HC		STREET ADDRESS, CITY, STATE, ZIP CODE 2748 CHICAGO AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
01910	Continued From page 29 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's record lacked documentation of medication disposition upon discharge. R1's discharge summary, dated July 30, 2023, indicated R1 received assistance with medication management. The discharge summary further indicated R1 discharged July 30, 2023, to another assisted living facility, and medications were sent with the resident and his case manager. The discharge summary noted R1 did not have any controlled medications. On January 9, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated R1 was not taking any narcotic medication, so they did not document his medication disposition upon discharge. -at 9:40 a.m., CNS-B stated she was not aware they needed to document all medications upon discharge, but understood the reason why they needed to be documented. The Licensee's Clinical Records policy, dated August 1, 2021, indicated a clinical record would be maintained for all residents including a discharge summary and related documentation, including service termination notice, when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910			

Type: Full
Date: 01/08/24
Time: 14:06:54
Report: 1036241006

Food and Beverage Establishment Inspection Report

Page 1

Location:

Metropolitan Sincerity Hc
2748 Chicago Avenue South
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:

ID #: 0038397
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124070378
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.

2-200 Employee Health**2-201.11C**

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. EXAMPLE MDH ILLNESS LOG EMAILED TO ESTABLISHMENT.

Comply By: 01/09/24

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.

OBSERVED OPEN CONTAINERS OF DAIRY CONTAINING COFFEE CREAMER SITTING OUT ON THE COUNTERTOP. ITEM DISCARDED ON SITE.

Comply By: 01/08/24

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.

OBSERVED OPENED PACKAGES OF CHEESE AND CONTAINERS OF YOGURT AND SOUR CREAM WITH NO DATE LABEL. COMPLY WITH ABOVE RULE.

Type: Full
Date: 01/08/24
Time: 14:06:54
Report: 1036241006
Metropolitan Sincerity Hc

Food and Beverage Establishment Inspection Report

Page 2

Comply By: 01/09/24

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 DEVICE ON SITE FOR MEASURING THE UST OF THE DISH MACHINE. MDH LEFT BEHIND A COUPLE TEST STRIPS UNTIL SOME CAN BE OBTAINED.

Comply By: 01/16/24

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.

OBSERVED LEFTOVER FOODS PREPARED THE PREVIOUS DAY BEING COLD HELD IN THE FRIDGE. DISCONTINUE SAVING AND SERVING LEFTOVERS. ITEMS DISCARDED ON SITE.

Comply By: 01/08/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

OBSERVED SOME FOOD DEBRIS/RESIDUE ACCUMULATION IN THE KITCHEN CABINETS AND DRAWERS. COMPLY WITH ABOVE RULE.

Comply By: 01/23/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 160 Degrees Fahrenheit

Location: DISHMACHINE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK

Temperature: 39 Degrees Fahrenheit - Location: KITCHEN FRIDGE

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 0 Degrees Fahrenheit - Location: KITCHEN FREEZER

Violation Issued: No

Process/Item: Ambient Temp/DAIRY CREAMER

Temperature: 68 Degrees Fahrenheit - Location: ON KITCHEN COUNTERTOP-DISCARDED

Violation Issued: Yes

Type: Full
Date: 01/08/24
Time: 14:06:54
Report: 1036241006
Metropolitan Sincerity Hc

**Food and Beverage Establishment
Inspection Report**

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS RENEE ANDERSON. INSPECTION CONDUCTED IN PRESENCE OF HAMZA MOHMED. ALL VIOLATIONS WERE DISCUSSED WITH ABDIWELI SHURIYE, THE CFPM AND HRD EVALUATOR DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

****IF ANY RESIDENTS COMPLAIN OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.**

Type: Full
Date: 01/08/24
Time: 14:06:54
Report: 1036241006
Metropolitan Sincerity Hc

Food and Beverage Establishment Inspection Report

Page 4

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

I acknowledge receipt of the inspection report number 1036241006 of 01/08/24.

Certified Food Protection Manager: ABDIWELI SHURIYE

Certification Number: FM120273 Expires: 11/13/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

HAMZA MOHMED
KITCHEN STAFF

Signed: _____

Jeff Johanson