Electronically Delivered

January 14, 2025

Licensee
Premium Home Healthcare LLC
6424 Fremont Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL35683015

Dear Licensee:

On December 16, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 2, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

November 4, 2024

Licensee
Premium Home Healthcare LLC
6424 Fremont Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL35683015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 2, 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.

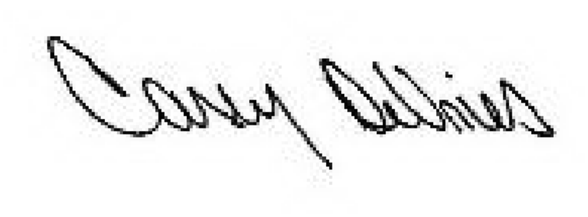
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35683	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIUM HOME HEALTHCARE LLC	6424 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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: SL35683015-0 On September 30, 2024, through October 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction are issued. At the time of the survey there were three residents residing at the facility, all three residents were receiving assisted living services. An immediate correction order was identified on October 1, 2024, issued for SL35683015-0, tag identification 0820. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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 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 October 1, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on October 3, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility.	0 570		

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0 570	Continued From page 2 The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license effective July 1, 2024, through June 30, 2025. On September 30, 2024, at 9:31 a.m. during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed a copy of the licensee's assisted living license located in the facility office. LALD/CNS-A stated the office door is usually locked. The surveyor explained the posted license was required to be near the main entrance of the facility and must be the original license, not a copy. LALD/CNS-A stated they would replace the copy with the original license and move the posting out of the office. On October 1, 2024, at 11:30 a.m., the surveyor observed the licensee moved their posted license	0 570		

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0 570	Continued From page 3 into the commons area of the facility; it was still a copy of the license and not the original license. On October 1, 2024, at 12:10 p.m., LALD/CNS-A stated they moved the license posting out of the office. The surveyor explained it was still a copy of the license and they needed to post the original license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) 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 tuberculosis (TB) testing was completed within 90 days prior	0 660		

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0 660	Continued From page 4 to the date of hire for one of one employee (certified nurse practitioner (CNP)-D). Further, the licensee failed to ensure a TB chest X-ray (CXR) was accompanied by a positive TB Mantoux (skin test) or blood test completed within 90 days prior to the CXR for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment was completed on April 29, 2024. The licensee was at a low risk level. CNP-D CNP-D was hired on October 4, 2023, to provide oversight to ULP and direct cares services for residents. CNP-D's employee record included a HealthPartners Clinic lab result dated September 18, 2017, with a negative TB Gold (TB blood test) result completed on September 14, 2017. The TB Gold test result exceeded the requirement to be completed no more than 90 days prior to the date of hire. ULP-B ULP-B was hired on January 3, 2023, to provide direct care services to residents.	0 660		

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0 660	Continued From page 5 ULP-B's employee record included a Northpoint test result for ULP-B's CXR completed on November 2, 2023, but lacked a required TB test completed by Mantoux skin test or blood test completed within 90 days prior to the CXR. On October 1, 2024, at 9:00 a.m., the surveyor observed ULP-B administer medications to R2's. On October 1, 2024, at 12:10 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A inquired if the surveyor could clarify TB testing requirements. LALD/CNS-A stated ULP-B told them they did have the required testing completed but could not remember where it was completed. LALD/CNS-A stated they did not have a positive Mantoux skin test or blood test completed within 90 days prior to CNP-D's CXR. LALD/CNS-A stated sending new staff members to be tested for TB is expensive and may just have to start doing it on their own. The Minnesota Department of Health TB FAQ, last updated on September 26, 2024, indicated TB testing should be dated within 90 days before hiring. It further indicated if the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated: "4. The baseline test may be either TST (2-step) or BAMT.	0 660		

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0 660	Continued From page 6 5. If the first-step TST is negative, the second-step TST will be administered 1-3 weeks after the first TST result was read. 6. If the first and second-step TST results are both negative, the person is classified as not infected with M. tuberculosis. Additional TB screening is not necessary unless an exposure to M. tuberculosis occurs. 7. Written documentation for all TST results includes the mm induration, the interpretation (either positive or negative), the date read and a signature on letterhead. 8. Employees with written documentation of a previous positive TST or BAMT do not need a repeat TST or BAMT: -Assess for current TB symptoms -If they provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. -If they do not have the written documentation from above, they must receive a chest x-ray to exclude a diagnosis of infectious TB disease before having direct patient contact. -Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time. -After the baseline chest x-ray is performed and the result is documented, repeat x-rays are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph. 9. Employees with a verbal, but undocumented, history of a previous positive TST or BAMT will undergo the same screening process as those without previous positive results. Staff should be encouraged to keep copies of the results of the TB screening, for future use."	0 660		

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0 660	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 preparedness plan (EPP) with all the required	0 680		

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0 680	Continued From page 8 content and to post it prominently in a conspicuous place for staff, residents, and visitors to view. 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 October 1, 2024, at 10:25 a.m., the surveyor reviewed the licensee's Emergency Preparedness Manual last updated on June 24, 2024, which lacked evidence of the following required information: - development of strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); - quarterly review of the missing resident plan; - designation of a qualified person, who is authorized in writing, to act in the absence of the administrator; - development of a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response - development and implementation of EP policies/procedures (P/P) based on the EP, risk assessment & communication plan; - shelter in place needs; - development of P/P for at minimum food, water and pharmaceutical supplies; - development of P/P for sewage and waste disposal; - development of P/P for system to track the	0 680		

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0 680	Continued From page 9 location of on-duty staff and sheltered residents; - development of P/P for if on-duty staff and sheltered residents are relocated, how the licensee must document the specific name/location of the receiving facility or other location; - development of P/P to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - development of P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - development of P/P to address: use of volunteers, including the process/role for integration; - development of P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - development of a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and - development of a communication plan which included: -method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care -means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) -means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR	0 680		

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0 680	Continued From page 10 164.510(b)(4). On October 1, 2024, at 12:10 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated their EPP did not address the above mentioned requirements. The licensee's Emergency Preparedness* policy, dated August 1, 2021, indicated: "[Licensee name] 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 plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee name] will implement the Emergency management program* as soon as the agency becomes aware of the existence of an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;	0 730		

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0 730	Continued From page 11 (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35683	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIUM HOME HEALTHCARE LLC	6424 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 730	Continued From page 12 included a discharge summary with required content 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on March 18, 2020, and was discharged on August 31, 2024. R1's Discharge Summary dated August 31, 2024, lacked a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, including baseline and current mental, behavioral, and functional status. On October 1, 2024, at 12:10 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not know the discharge summary requirements and would include the required content going forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

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	35683	A. BUILDING: _____ B. WING _____	10/02/2024

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0 780	Continued From page 13 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 functioned and were interconnected so that the actuation of one alarm caused 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 cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 780		

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0 780	Continued From page 14 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 1, 2024, at 11:10 a.m. to 12:15 p.m., the surveyor toured the facility with house manager (HM)-C. The surveyor tested the smoke alarms throughout the home. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: The smoke alarms were not interconnected throughout the facility and the smoke alarm in the basement next to the laundry room was not interconnected to the rest of the facility. These deficient conditions were visually verified by HM-C accompanying on the tour and stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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	0 810		

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0 810	Continued From page 15 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 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 16 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 1, 2024, at 11:30 a.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 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. LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820		

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0 820	Continued From page 17 (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 had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 01, 2024, at 10:20 a.m. to 11:50 a.m., surveyor toured the facility with house manager (HM)-C. During the tour, survey staff asked HM-C	0 820		

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0 820	Continued From page 18 to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOM: Bedroom 3: Window measured 34 inches clear width, 16.5 inches clear height, and 563 square inches total open area. UNOCCUPIED SLEEPING ROOM: Bedroom 1: Window measured 33.5 inches clear width, 17 inches clear height, and 569.5 square inches total open area. The windows in bedrooms 1 and 3 did not meet the minimum requirements for opening height. The windows in bedrooms 1 and 3 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. Survey staff explained to HM-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. TIME PERIOD FOR CORRECTION: Immediate During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 820		

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01610	Continued From page 19	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment on, or before, the date of admission for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01610		

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01610	Continued From page 20 The findings include: R2 was admitted to the licensee on April 20, 2024. R2's Plan of Care and Service Plan dated April 26, 2024, indicated R2 received services for housekeeping, laundry, shopping, appointment assistance, transportation, socialization, meals, activities of daily living (ADLs) and medication management. R2's Resident Evaluation/Baseline Assessment dated April 21, 2024, indicated R2 did not receive an admission assessment on, or before their date of admission. The assessment was completed one day after their admission. R2's record contained no assessments completed prior to the April 21, 2024 assessment. On September 30, 2024, at 9:55 a.m. during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they completed their admission assessment within five days of admission; they did not want to bother the resident as it was stressful for residents when moving to the facility. On October 1, 2024, at 12:10 p.m., LALD/CNS-A stated they believed they had to complete a residents admission assessment with five days after admission. The surveyor provided LALD/CNS-A with the licensee's Assessment and Reassessment policy dated August 1, 2021, which indicated, "The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier." LALD/CNS-A stated they didn't like to complete an admission assessment	01610		

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01610	Continued From page 21 on the date of admission and was unfair to the client. The surveyor explained the admission assessment could be completed prior to the day of admission if that were their concern. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated, "The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		

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

Type: Full
Date: *10/01/24*
Time: 10:00:00
Report: 1043241287

Food and Beverage Establishment Inspection Report

Location:
Premium Home Healthcare Llc
6424 Fremont Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0037992
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635688828
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

FACILITY ONLY HAS A THICK PROBE THERMOMETER. ADVISED STAFF TO PROVIDE A THIN PROBE THERMOMETER FOR MEASURING INTERNAL FOOD TEMPERATURES. COMPLY WITH ABOVE RULE.

Comply By: 10/01/24

6-200 Physical Facility Design and Construction

6-202.15A

MN Rule 4626.1395A Seal holes, gaps, and other openings along floors, walls and ceilings to the outside of the building and provide self-closing, tight-fitting doors and windows for all outside openings.

1. SCREEN TO EXIT DOOR IN KITCHEN OBSERVED RIPPED ALONG THE EDGES. 2. GAP OBSERVED AT BOTTOM CORNER OF EXIT DOOR IN KITCHEN. ADVISED STAFF TO REPAIR/REPLACE ITEMS TO PREVENT PEST ENTRANCE. COMPLY WITH ABOVE RULE.

Comply By: 10/01/24

Surface and Equipment Sanitizers

HOT WATER: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *10/01/24*
Time: 10:00:00
Report: 1043241287
Premium Home Healthcare Llc

Food and Beverage Establishment Inspection Report

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

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

Inspection was completed with Joey Keen as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations, discard any leftovers by the end of the day. Staff supervision must be provided to ensure proper/safe food handling procedures and cooking temperatures if/when foods are cooked/reheated by clients.

This facility has a residential kitchen with residential equipment, blue painted wooden cabinetry, and laminated flooring. Utensil surface temperature of residential dish machine must reach at least 160F degrees (or 150F degrees for NSF/ANSI 184 residential dish machine). Sanitizing option on dish machine must always be used when running a cycle.

***Notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

Type: Full
Date: *10/01/24*
Time: 10:00:00
Report: 1043241287
Premium Home Healthcare Llc

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 1043241287 of 10/01/24.

Certified Food Protection Manager: Ifeyinwa Osakwe

Certification Number: FM107559 Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Ifeyinwa Osakwe
Assisted Living Director

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us