



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 22, 2024

Licensee
Abraham's Bosom Care LLC
437 Tower Street
Saint Paul, MN 55119

RE: Project Number(s) SL35624015

Dear Licensee:

On January 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 1, 2023, 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 that reads 'Casey DeVries'.

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

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

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December 11, 2023

Licensee

Abraham's Bosom Care LLC

437 Tower Street

Saint Paul, MN 55119

RE: Project Number(s) SL35624015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

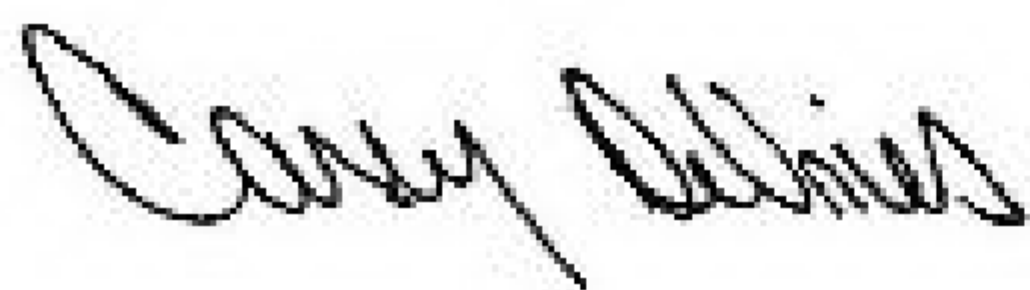
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/01/2023
NAME OF PROVIDER OR SUPPLIER ABRAHAM'S BOSOM CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 437 TOWER STREET SAINT PAUL, MN 55119		
(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35624015-0 On October 30, 2023, through November 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents receiving services under the Assisted Living license. An immediate correction order was identified on October 30, 2023, issued for SL35624015-0, tag identification 1290. On October 31, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on October 31, 2023, issued for SL35624015-0, tag identification 0820.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 250			

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0 250	Continued From page 3 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license renewal effective April 1, 2023, with an expiration date of March 31, 2024. The licensee's Application for Assisted living License, signed December 28, 2022, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), indicated, "I certify I have read and understand the following:" A check mark, indicating understanding, was placed before each of the following: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.	0 250			

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0 250	Continued From page 4 - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing	0 250			

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0 250	Continued From page 5 the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner, licensed assisted living director/registered nurse (LALD/RN)-A on December 28, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis (TB), consistent with current United States Centers for Disease Control and Prevention standards; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or	0 250			

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0 250	Continued From page 6 appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; and - medication management; - delegation of tasks by registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. The licensee's renewal application signed by owner, LALD/RN-A on June 1, 2022, also indicated check marks attesting LALD/RN-A understood Assisted Living Licensure laws, rules, and statutes, as listed above. The renewal application further indicated LALD/RN-A understood LALD/RN-A was "legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." October 30, 2023, at 9:48 a.m., during the entrance conference, LALD/RN-A stated they were in charge of the day-to-day operations of the facility and were familiar with the regulations for an Assisted Living and stated, "I'm still learning." LALD/RN-A further stated the licensee provided the following services: medication and treatment management, staff orientation and training, and delegation of tasks by the RN to ULPs. The licensee failed to implement the corresponding policies and procedures, as required. As a result of this survey, 27 correction orders were issued: 250, 0470, 0480, 0550, 0640, 0650, 0660, 0680, 0730, 0780, 0800, 0810, 0820, 1290, 1370, 1500, 1530, 1610, 1620, 1650, 1760, 1820, 1880 and 1910 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with	0 250			

Minnesota Department of Health

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0 250	Continued From page 7 Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced	0 470			

Minnesota Department of Health

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0 470	Continued From page 8 by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was completed and reviewed two times per year. 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 licensee's staffing plan, undated and untitled, described a "map" and grid they would use to figure out their staffing needs, but the grid was not completed. On October 30, 2023, at 9:48 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated they had a staffing plan and thought it was updated sometime in March 2023. On October 31, 2023, at 12:27 p.m., LALD/RN-A confirmed there was no revision date on the staffing plan they provided. LALD/RN-A also stated they might have read the twice-yearly revision of the staffing plan requirements somewhere, but they could not be sure if they knew it was a requirement or not. The licensee's 4.06 Staffing & Scheduling policy dated June 1, 2022, indicated "1. The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the	0 470			

Minnesota Department of Health

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0 470	Continued From page 9 residents' needs 24-hours a day, seven-days a week." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the additional documentation included in the Food and Beverage Establishment	0 480			

Minnesota Department of Health

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0 480	Continued From page 10 Inspection Report (FBEIR) dated October 30, 2023. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and The Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), Minnesota Adult Abuse Reporting Center (MAARC), and Office of Health Facility Complaints (OHFC).	0 550			

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0 550	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, at 10:45 a.m., during the facility tour, licensed assisted living director/registered nurse (LALD/RN)-A stated they had to take down some of their postings due to an incident with a resident. The surveyor observed the licensee lacked the following postings: - OOLTC; - OMHDD; - MAARC; and - OHFC. On November 1, 2023, at 11:45 a.m., LALD/RN-A stated an unhappy resident threw a drink at a staff member and the drink got on the postings. LALD/RN-A stated they had to take the postings down and forgot to put them back up. LALD/RN-A showed the surveyor they had created a form with the required posting information and posted it on the living room wall during survey. The licensee's Complaint/Grievance Posting policy dated June 1, 2022, indicated: "Procedure: 1. Abraham's Bosom Care LLC will post, in a conspicuous place, information about our complain/ grievance procedure and the name, telephone number, and email contact information	0 550			

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0 550	Continued From page 12 for the individual(s) who are responsible for handling resident compliant/grievances. 2. The postings will also have the contact information for the office of ombudsman for long term care and the ombudsman for mental health and developmental disabilities a. OFFICE OF OMBUDSNAN FOR LOGTERM CARE PO BOX 64971 St. Paul. MN 55164-0971 1-800-657-3591 or 651-431-2555 Email: MBA.OOLTC@state.mn.us http://www.mnaging.org/Advocate/OLTC.aspx b. OFFICE OF OMBUDSNAM FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES 121 7th Place East Metro Square Building St. Paul, MN 55101-2117 1-800-657-3506 or 651-757-1800 Email: Ombudsman.mdh@state.mn.us https://mn.gov/omhdd/ 3. In addition, the postings will include information for reporting suspected maltreatment to the Minnesota Adult Abuse Center a. MINNESOTA ADULT ABUSE REPORTING CENTER (MAARC) Phone: 1-844 880 1574 For more information: https://mn.gov/dhs/adult-protection No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640			

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0 640	Continued From page 13 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency phone number in common areas and by the house phones. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 30, at 9:48 a.m., during the entrance conference, the surveyor inquired if licensed assisted living director/registered nurse (LALD/RN)-A was familiar with current minimum assisted living requirements. LALD/RN-A stated, "I'm still learning."	0 640			

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0 640	Continued From page 14 On October 30, 2023, at 10:45 a.m., during the facility tour, the surveyor observed the front entrance, common areas and house phone located on the medication cart in the living room which lacked the required posting for the 911 emergency phone number. LALD/RN-A stated the house phone was used by staff, residents and visitors. LALD/RN-A stated they were unaware of the requirement for the 911 postings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and	0 650			

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0 650	Continued From page 15 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required annual performance reviews for one of three employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired March 29, 2021, to provide direct care services to residents. On October 31, 2023, the surveyor observed ULP-C provide direct cares to residents throughout the day. ULP-C's employee record included one Annual Performance Review Form dated March 30, 2022. ULP-C's employee record lacked an annual performance review due to be completed by March 30, 2023. On October 31, 2023, at 11:30 a.m., registered nurse (RN)-F provided an Evaluation Form dated August 1, 2023, which was a self-evaluation completed by ULP-C. RN-F stated, "this is what we use."	0 650			

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0 650	Continued From page 16 On November 1, 2023, at 1:03 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated employees filled out the Evaluation Form annually, and the RN would review the form with the ULPs and fill out the Annual Performance Evaluation Form. LALD/RN-A would not clarify why the annual performance evaluation was not completed. The licensee's 4.05 Employee Records policy dated June 1, 2022, indicated employee records for each person would include, "Documentation of annual performance reviews that identify areas of improvement needed and training needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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	0 660			

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0 660	Continued From page 17 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 a Tuberculosis (TB) Risk Assessment Form was completed. The licensee also failed to ensure annual TB training was completed for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB RISK ASSESSMENT The licensee's TB Risk Assessment completed on April 6, 2022, lacked the following: - TB risk level for the facility; - Type of setting; - Minnesota rate of TB infection; - Name of a person responsible for TB infection control or infection control committee members; and - Review of current TB risk assessment. ANNUAL TB TRAINING ULP-B was hired on August 31, 2020, to provide direct cares for residents. On October 31, 2023, the surveyor observed ULP-B provide direct cares to residents throughout the day.	0 660		

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0 660	Continued From page 18 ULP-B's Educare (online training platform) transcript indicated their last TB training was completed on September 21, 2021, under the OSHA and Infection Control training module. ULP-B's employee record lacked annual TB training due to be completed by September 21, 2022, and September 21, 2023. On November 1, 2023, at 11:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they were not aware the TB Risk Assessment lacked the required information. LALD/RN-A stated they trained all employees yearly and had them fill out the TB symptoms screening. LALD/RN-A stated, "If you did not find it in the transcripts, then it is not there." The licensee's 8.16 TB Screening policy dated August 1, 2021, indicated: "POLICY: Abraham's Bosom Care LLC will 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 (MMWR). The program includes a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers PROCEDURE: 1. The facility will identify an individual staff member responsible for the TB program. 2. The facility will maintain a current community TB risk assessment. The assessment will be updated	0 660			

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0 660	Continued From page 19 annually, using the data and form provided by the Minnesota Department of Health Staff Education Staff will be educated regarding TB at time of hire. The content of the training should be appropriate to the job responsibilities and educational or professional background of the employee (licensed versus unlicensed staff). Content of the training will focus on basic information about: 1. TB pathogenesis and transmission 2. Signs and symptoms of active TB disease, and 3. [Name of AL] infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure}, especially any sections that employees are responsible for implementing." The Minnesota Department of Health Assisted Living Resources & Frequently-Asked Questions (FAQs) for Tuberculosis indicated, "All Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. TB education should include information on TB exposure risk factors (both occupational and nonoccupational), the signs and symptoms of TB disease, and TB infection control policies and procedures." The Centers for Disease Control and Prevention for Tuberculosis (TB) Screening, Testing, and Treatment of U.S. Health Care Personnel Frequently Asked Questions (FAQs) dated as last reviewed June 26, 2019, https://www.cdc.gov/tb/topic/infectioncontrol/healthcarepersonnel-faq.htm indicated annual TB education for all health care personnel should include information about TB risk factors, the signs and symptoms of TB disease, and TB	0 660			

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0 660	Continued From page 20 infection control policies and procedures. 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 observation, interview, and record	0 680			

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0 680	Continued From page 21 review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Manual, revised in July 2021 was developed through utilization of a template provided by a home care consultant. The EPP was not posted prominently, was not tailored to the facility's specific information or needs, and lacked the following: - establish and maintain a comprehensive EP, reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans,	0 680			

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0 680	Continued From page 22 staffing/shortage, back-up plans); - missing resident plan; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop and implement EP policies/procedures and review/update annually; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions; - alternate sources of energy to fire detection, extinguishing, alarms systems; - sewage and waste disposal; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures to address safe evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - alternate communication means; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality;	0 680			

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0 680	Continued From page 23 - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; - volunteers; - communication plan must include; - method for sharing information and medical documentation for residence; - means, in event of evacuation, to release resident information; - means of providing information about general condition and location of residents under [licensee's] care; - communication plan must include: - means to provide information about facility occupancy; - needs; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include A method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually;	0 680			

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0 680	Continued From page 24 - training program must include initial EP training to policies and procedures to all new and existing staff and volunteers; - provide EP training at least annually; - maintain documentation of EP training; - demonstrate staff knowledge of EP; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. On October 31, 2023, at 12:27 p.m., the surveyor observed the EPP was stored on a filing cabinet in the basement. The licensed assisted living director/registered nurse (LALD/RN)-A stated it was stored there and was not displayed prominently anywhere else in the facility. On October 31, 2023, at 12:48 p.m., LALD/RN-A stated they thought they had completed the EPP but must not have. LALD/RN-A acknowledged their EPP was missing a lot of information and was not tailored to their facility's needs. On November 1, 2023, at 1:20 p.m., LALD/RN-A stated they were aware of the EPP requirements and had purchased it from a home care consultant and believed it to include all of the required information. The surveyor explained what they had was an EPP template, and still required the licensee to add in information to tailor it to their licensee's specific information and needs. LALD/RN-A stated they completed the EPP for their other licensed facility but must have overlooked updating the EPP for this licensee.	0 680			

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0 680	Continued From page 25 The administrative assistant (AA)-E, also present during the interview, acknowledged the EPP needed to be updated. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "Abraham's Bosom Care 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." No further information 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; (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	0 730			

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0 730	Continued From page 26 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 observation, interview, and record review, the licensee failed to ensure the resident record included documentation of all services provided 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	0 730			

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0 730	Continued From page 27 of the residents). The findings include: SERVICE DOCUMENTATION R2 R2's Service Agreement/Plan dated December 21, 2022, indicated R2 received services for bathing, activities of daily living, ambulation, laundry, light housekeeping, blood sugars checks, medication management, psychiatric management, medication administration, medication reminders, transportation, meal preparation, and social activities. R2's Service Recap Summary for October 1-31, 2023, lacked documentation for 528 services provided during multiple services and shifts. R3 R3's Service Plan dated December 28, 2022, indicated R3 received services for dressing, oral hygiene, grooming, bathing, medication set up, medication administration, homemaking assist, personal laundry, linen change, housekeeping, and behavior monitoring. R3's Service Recap Summary for October 1-31, 2023, lacked documentation for 413 services provided during multiple services and shifts. On November 1, 2023, at 1:30 p.m., LALD/RN-A stated staff were supposed to document service administrations when completed and document refusal when resident's refuse services. There should never be empty charting on the Service Recap summaries. LALD/RN-A stated they did not go through service charting every day to check if documentation was done but it was their expectation for the staff to complete the	0 730			

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0 730	Continued From page 28 documentation in Rtask (electronic medical record). 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 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:	0 780			

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0 780	Continued From page 29 Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling 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 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on October 31, 2023, at 12:14 p.m., with licensed assisted living director/registered nurse (LALD/RN)-A, survey staff observed smoke alarms throughout the facility were not interconnected so the actuation of one alarm will cause all alarms in the dwelling to actuate evident when LALD/RN-A tested the smoke alarms. On October 31, 2023, at 12:14 p.m., LALD/RN-A confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800			

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0 800	Continued From page 30 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the 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 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 October 31, 2023, at 1:56 p.m., survey staff toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A. During the facility tour, survey staff observed and verified the following maintenance issues: 1. It was observed in the basement bathroom, the walls had unfinished drywall, the flooring was cement and the ceiling was bare studs. 2. It was observed that cigarette butts were lying all over the yard right next to the house. A wired basket was provided to dispose of the cigarette	0 800			

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0 800	Continued From page 31 butts but it is not always being used and unable to keep these butts contained. LALD/RN-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or 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	0 810			

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0 810	Continued From page 32 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, provide required employee and resident training on fire safety and evacuation, and conduct required evacuation drills. 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 1, 2023, licensed assisted living director/registered nurse (LALD/RN)-A provided documentation on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated the evacuation plan did not include employee actions to be taken in the event of a fire or similar emergency. The current plan used the standard RACE (Remove, Alarm, Confine and	0 810			

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0 810	Continued From page 33 Extinguish or Evacuate) directive, however did not include facility specific emergency risk situational actions for employees to execute in case of an emergency. Record review of the available documentation indicated the evacuation plan did not include complete procedures for residents' evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation lacked documentation the licensee provided training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year, per shift and every other month for employees as required by statute. Documentation showed evacuation drills were done two times in 2023. During interview on November 1, 2023, at 9:45 a.m, LALD/RN-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=I	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	0 820			

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0 820	Continued From page 34 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 provide properly sized egress windows for resident rooms that did not create a distinct hazard for residents. This had the potential to directly affect a portion of the residents and staff. 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 31, 2023, at 1:45 p.m., survey staff conducted a facility tour with Licensed Assisted Living Director/Registered Nurse (LALD/RN-A). During facility tour, survey staff observed the following: LALD/RN-A fully opened the proposed egress	0 820	This immediate correction order identified on October 31, 2023, has had the immediacy lifted as of November 1, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 35 window in occupied resident room #1 and survey staff verified the measurement of the openable area of the window to be 18.75" high x 34.5" wide for a total of 646 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". LALD/RN-A visually verified the deficient condition. LALD/RN-A fully opened the proposed egress window in unoccupied resident room #2 and survey staff verified the measurement of the openable area of the window to be 18.75" high x 35" wide for a total of 656 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". LALD/RN-A visually verified the deficient condition. LALD/RN-A fully opened the proposed egress window in occupied resident room #3 and survey staff verified the measurement of the openable area of the window to be 19.75" high x 35" wide for a total of 691 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". LALD/RN-A visually verified the deficient condition. LALD/RN-A fully opened the proposed egress window in occupied resident room # 5 and survey staff verified the measurement of the openable area of the window to be 27.75" high x 17.75" wide for a total of 492 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width	0 820			

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0 820	Continued From page 36 dimension of no less than 20". LALD/RN-A visually verified the deficient condition. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	0 820			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of four employees (unlicensed personnel (ULP)-B, ULP-C, ULP-D). 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,	01290	On October 31, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained and the scope and level remained unchanged.		

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01290	Continued From page 37 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: The licensee had a former comprehensive home care license which was no longer active under health facility identification number (HFID) 35340 in Minnesota Department of Human Services NETStudy 2.0 (web-based system used to submit background study requests). ULP-B ULP-B was hired on October 26, 2020. ULP-B's employee record contained a background study (BGS) dated August 17, 2020, affiliated to HFID 35340. ULP-B's record lacked evidence the licensee submitted a BGS for ULP-B under the licensee's current assisted living HFID 35624. ULP-C ULP-C was hired on March 29, 2021. ULP-C's employee record contained a BGS dated March 23, 2021, affiliated to HFID 35340. ULP-C's record lacked evidence the licensee submitted a BGS for ULP-C under the licensee's current assisted living HFID 35624. ULP-D ULP-D was hired on October 26, 2020. ULP-D's employee record contained a BGS dated August 17, 2020, affiliated to HFID 35340.	01290			

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01290	Continued From page 38 ULP-D's record lacked evidence the licensee submitted a BGS for ULP-D under the licensee's current assisted living HFID 35624. The licensee provided a staff roster which included seven staff members hired prior to August 1, 2021, when the new assisted living regulations went into effect. On October 30, 2023, at 11:20 a.m., the surveyor observed the licensee's NetStudy2.0 records in the presence of licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A stated their comprehensive home care license was no longer active and stated multiple staff members did not have a new BGS completed under their new HFID 35624. On October 30, 2023, at 12:00 p.m., LALD/RN-A stated they forgot to run the older employees hired prior to August 1, 2021, under the licensee's new HFID number which included the majority of the licensee's staff. LALD/RN-A stated it was their job to ensure the BGS were completed. The licensee's 4.02 Background Study policy dated June 1, 2022, indicated: "1. Using the MN OHS NetStudy online program, Abraham's Bosom Care LLC will initiate a background study on all employees being considered for hire. 2. If hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients of Abraham's Bosom Care LLC except under the direct supervision (eyesight) of another qualified staff person. 3. Once an approved background study has been	01290			

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01290	Continued From page 39 received, staff may ad independently with residents, assuming all other requirements have been met. 4. Copies of completed background studies shall be kept in individual employee records." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional;	01370			

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01370	Continued From page 40 (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required competency training was completed for one of two unlicensed employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on October 26, 2020, and provided direct care services to the licensee's residents. On October 31, 2023, the surveyor observed ULP-B provide direct cares to residents throughout the day.	01370			

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01370	Continued From page 41 ULP-B's employee record lacked the following documentation of required competency training to be completed by a registered nurse (RN): - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) assisting with toileting; and - standby assistance techniques and how to perform them. On November 1, 2023, at 11:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they did focused training with the ULP's, they did not have any resident who required the above-mentioned cares. They did not think the training was relevant to their employees, since they did not have resident who required the cares. The licensee's Competency Training Evaluation policy dated June 1, 2022, indicated: "4. Training and competency evaluations of ULP's will be conducted by a RN, or another instructor may provide the training in conjunction with a RN; 5. Training and competency evaluations for all ULP's will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic	01370			

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01370	Continued From page 42 devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:	01500			

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01500	Continued From page 43 (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated	01500			

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01500	Continued From page 44 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment in all required training topics for one of three direct care employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on October 26, 2020, and provided direct care services to the licensee's residents. On October 31, 2023, the surveyor observed ULP-B provide direct cares to residents throughout the day. ULP-B's employee record included an Educare (online training platform) transcript which lacked	01500			

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01500	Continued From page 45 annual training for the following required topics: - assisted living bill of rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with resident's who have dementia, Alzheimer's disease or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning/service deliver. On November 1, 2023, at 11:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they thought they had completed the required annual trainings on Rtask (electronic medical record), but they had not. They stated the Educare transcript and Certificates of Completion were the only training documents they had to provide. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;	01530			

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01530	Continued From page 46 (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide two hours of required annual dementia care training, for one of three direct care employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on October 26, 2020, and provided direct care services to the licensee's residents.	01530			

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01530	Continued From page 47 On October 31, 2023, the surveyor observed ULP-B provide direct cares to residents throughout the day. ULP-B's employee record included an Educare (online training platform) transcript which indicated their last dementia care training was completed on September 7, 2021. ULP-B's employee record lacked annual dementia care training due to be completed by September 7, 2022, and September 7, 2023. On November 1, 2023, at 11:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they thought ULP-B completed the required two hours of dementia care training on Rtask (electronic medical record), but they had not. They stated the Educare transcripts and Certificates of Completion were the only training documents they had to provide. The licensee's 5.03 Dementia Training policy dated June 1, 2022, indicated, "All staff will complete two (2) hours of additional training for each 12 months of work thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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.	01610			

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01610	Continued From page 48 (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 a comprehensive nursing assessment required on or before the move-in date 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on December 28, 2022. R3's Service Plan dated December 28, 2022,	01610			

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01610	Continued From page 49 indicated R3 received medication management services, bathing, homemaking, housekeeping, and behavior monitoring. R3's record included an Admission Assessment completed on December 31, 2022, three days after R3's admission to the licensee. On October 30, 2023, at 9:48 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated nursing would ideally go to the resident and do a preadmission assessment to make sure the resident was appropriate for their facility. The next assessment would be completed on the actual date of admission. On November 1, 2023, at 1:20 p.m., LALD/RN-A stated they do a preassessment before a resident is accepted and then another assessment at the time of admission. LALD/RN-A acknowledged R3's admission assessment was completed late. LALD/RN-A then provided a form which they identified as a preassessment for R3. They stated they created a form to do a preassessment on paper and was not uploaded into Rtask (charting software). It had R3's name on it but was not signed or dated. The assessment was neither comprehensive (contained topics required by Minnesota Administrative Rule 4659.0150 Subpart 2) nor was it completed. LALD/RN-A stated the assessment was lacking nearly all information expected in a comprehensive nursing assessment. LALD/RN-A stated they needed to create a new system and forms to ensure preadmission and admission assessments were documented. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated June 1, 2022, indicated:	01610			

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01610	Continued From page 50 Abraham's Bosom Care LLC will 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. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
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	01620			

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01620	Continued From page 51 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 a reassessment every 90-days 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 was admitted to the licensee on July 30, 2020. R2's Service Agreement/Plan dated December 21, 2022, indicated R2 received medication management services, bathing, meal prep, social activities, laundry, and light housekeeping. R2's record included an Annual Assessment completed on October 13, 2021, and no further assessments were completed thereafter. It had been more than two years since R2's last documented assessment which were required every 90-days. R3 R3 was admitted to the licensee on December 28, 2022.	01620		

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01620	Continued From page 52 R3's Service Plan dated December 28, 2022, indicated R3 received medication management services, bathing, homemaking, housekeeping, and behavior monitoring. R3's record included an Admission Assessment completed on December 31, 2022, and their next assessment was not completed until August 1, 2023. It had been more than seven months between R3's assessments which were required every 90-days. On October 30, 2023, at 9:48 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated they completed nursing assessments starting with a preadmission assessment, admission assessment, 14-day assessment and then every 90-days thereafter. On October 31, 2023, at 8:40 a.m., LALD/RN-A stated they provided the surveyor with all of R2's assessments and what was visible in Rtask (charting software) were the only assessments they had to provide. LALD/RN-A acknowledged R2's record lacked an assessment since October 13, 2021. On October 31, 2023, at 12:48 p.m., LALD/RN-A stated they provided the surveyor with all of R3's assessments, and what was visible in Rtask were the only assessments they had to provide. LALD/RN-A acknowledged R3's record lacked multiple 90-day assessments. On November 1, 2023, at 1:20 p.m., LALD/RN-A stated 90-day assessments were not completed and was the responsibility of LALD/RN-A and RN-F. LALD/RN-A stated they were in the process of contacting Rtask to figure out how	01620			

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NAME OF PROVIDER OR SUPPLIER ABRAHAM'S BOSOM CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 437 TOWER STREET SAINT PAUL, MN 55119			
(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 53 they could utilize it to remind them when an assessment was due to be completed. The licensee's 6.01 Assessment, Reviews & Monitoring policy dated June 1, 2022, indicated, "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." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an	01650			

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NAME OF PROVIDER OR SUPPLIER ABRAHAM'S BOSOM CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 437 TOWER STREET SAINT PAUL, MN 55119		
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01650	Continued From page 54 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include required service plan content 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 was admitted to the licensee on July 30, 2020. R2's Service Agreement/Plan dated December 21, 2022, indicated R2 received medication management services, bathing, meal prep, social activities, laundry, and light housekeeping. The service plan lacked the following requirements: -the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650			

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01650	Continued From page 55 -the identification of staff or categories of staff who will provide the services; and -the schedule and methods of monitoring assessments of the resident. Additionally, R2's Service Recap Summary for October 2023, included the following documented services provided which were not included on R2's most recent Service Agreement/Plan dated December 21, 2022: -specific managed behaviors; -meal reminders; -safety checks; -symptom screening; -exercise; -linen change; and -shopping assistance. R3 R3 was admitted to the licensee on December 28, 2022. R3's Service Plan dated December 28, 2022, indicated R3 received medication management services, bathing, homemaking, housekeeping, and behavior monitoring. The service plan lacked the following requirements: -the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; and -the identification of staff or categories of staff who will provide the services. Additionally, R3's Service Recap Summary for October 2023, included the following documented services provided which were not included on R3's most recent Service Plan dated December 28, 2022: -specific managed behaviors; -meal reminders;	01650			

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01650	Continued From page 56 -activity assistance; -symptom screening; and -exercise. On November 1, 2023, at 1:20 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated it was their responsibility to make sure service plans were updated and signed. LALD/RN-A stated they had a nurse employed who helped manage service plans, but they were not doing their job and the licensee had to terminate their employment. LALD/RN-A stated they hired RN-F who was becoming more involved with service plans. LALD/RN-A acknowledged the discrepancies between R2 and R3's service plans and service documentation and stated they had not been updated as required. The licensee's 6.08 Service Plan policy dated June 1, 2022, indicated: "2. The service plan and any revisions shall include a signature or other authentication by Abrahams Bosom Care LLC and by the resident, or resident's representative, documenting agreement on the services to be provided. 3. Services plans shall be revised, if needed, based on resident reassessments and monitoring. 4. Services plans shall include fees for the services indicated in the service plan. 9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of	01650			

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01650	Continued From page 57 staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: i. Actions Abraham's Bosom Care LLC will take if scheduled services cannot be provided ii. Information regarding how the resident can contact Abraham's Bosom Care LLC iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any -including circumstances when emergency medical services are not to be summoned." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
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	01760			

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01760	Continued From page 58 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document medication administration 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 List of Services to be Provided/Service Plan dated December 21, 2022, indicated R2 received medication management services. R2's medication administration record (MAR) for October 1-30, 2023, indicated R2 took the following scheduled medications: benztropine 0.5 milligrams (mg) tablet, diphenhydramine 50mg capsule, divalproex 250mg ER tablet, glipizide 10mg tablet, Metformin 1000mg tablet, metoprolol succinate 25mg extended release (ER) tablet, rosuvastatin 5mg tablet, sitagliptin 50mg, Trulicity 1.5/0.5 injection, Urea 40%	01760			

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01760	Continued From page 59 cream, Vraylar 1.5mg capsule. R2's MAR lacked documentation of medication administration 127 times for multiple medications and shifts. R3 R3's Service Plan dated December 28, 2022, indicated R3 received medication management services. R3's MAR for October 1-30, 2023, indicated R2 took the following scheduled medications: clozapine 200mg, diphenhist 25mg capsule, prazosin hydrochloride (HCL) 1mg capsule, Valacyclovir 500mg tablet. R2's MAR lacked documentation of medication administration 39 times for multiple medications and shifts. On November 1, 2023, at 1:20 p.m., licensed assisted living director/registered nurse (LALD/RN)-A acknowledged the missing MAR documentation. LALD/RN-A stated the residents often refused to take medications or might be given late so staff were unable to go back and document it due to Rtask (charting software) not allowing them to. LALD/RN-A some staff were not utilizing Rtask correctly and residents would change their mind frequently as to whether they would take their medications. LALD/RN-A stated staff should be documenting administration or refusal no matter what. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated June 1, 2022, indicated: "1) The following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: a. The date, b. The time,	01760		

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01760	Continued From page 60 c. The quantity of dosage, d. The method of administration of all prescribed legend and over-the-counter medications and or treatments/therapy e. Signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy 2) If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. 3) Documentation of medication/treatment/therapy reminders, medication/treatment/therapy assistance or medication/treatment/therapy administration will be completed by the person who performed the task immediately after the medication assistance/administration is completed. 4) Document special occurrences as follows: a. Medication and/or Treatment/Therapy Refused -To indicate the medication/treatment was refused, circle your initials and write a capital R in the same box on the MAR or TAR form. b. Medication/Treatment/Therapy Held -To indicate the medication/treatment was held, circle your initials and write a capital H in the same box on the MAR or TAR form. c. There is an area on the reverse side of the MAR from marked "Special Remarks." This is the designated area to document the reason for refusal, held, PRN given, etc. 5) A signature page must be filled out if using initials for verification. The signature page will include name, initials, title and signature. 6) Abraham's Bosom Care LLC will document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible consequences of the	01760			

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01760	Continued From page 61 resident's refusal and document the discussion in the resident's record" No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=F	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 interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained 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 was admitted to the licensee on June 30, 2020. R2's List of Services to be Provided/Service Plan	01820			

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01820	Continued From page 62 dated December 21, 2022, indicated R2 received medication management services. R2's record included four After Visit Summary's (AVS) which lacked orders both signed and dated by R2's provider: -Medication discharge list (AVS) dated December 13, 2022, lacked a signature and indicated, "Individual Medication and other orders electronically signed in the source EMR (Electronic Medical Record)"; there were no individual signed prescriber's orders to accompany the discharge paperwork. -Discharge Instructions (AVS) printed on December 13, 2022, contained a medication print out of known home medications and instructions for medication regimen changes. The AVS lacked a prescriber's signature to authenticate the medication list; -AVS dated June 23, 2023, contained a medication print out of known home medications. The AVS lacked a prescriber's signature to authenticate the medication list and included a statement, "Always use your most recent med list. Please let us know if anything is missing including supplements or other medications." -AVS dated July 21, 2023, contained a medication print out of known home medications and instructions for medication regimen changes. The AVS lacked a prescriber's signature to authenticate the medication list and included a statement, "Please let us know if anything is missing including supplements or other medications." R2's most recent AVS dated July 21, 2023, indicated R2 was taking the following medications: -benztropine 0.5 milligrams (mg) tablet, take one tablet daily by mouth (PO);	01820			

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01820	Continued From page 63 -diphenhydramine 50mg capsule, take 1 capsule PO every night at bedtime; -divalproex 250mg ER tablet, give two tablets (500mg) PO every night at bedtime; -melatonin 3mg tablet, take one tablet PO at bedtime as needed (PRN); -methocarbamol 500mg tablet, take one tablet PO three times per day; -metoprolol succinate 25mg extended release (ER) tablet, take one tablet PO daily; -olanzapine 5mg tablet, take one tablet PO three times per day PRN for paranoia and agitation; -trazodone 100mg tablet, take one tablet PO at bedtime PRN for sleep; and -Vraylar 1.5mg capsule, take 1 capsule (1.5mg) by mouth daily at bedtime. R2's MAR for October 2023, indicated the licensee was administering the following medications to R2: -benzonatate 100mg, take one capsule PO three times daily as needed (PRN) for cough; -benztropine 0.5 milligrams (mg) tablet, take one tablet daily by mouth (PO); -diphenhydramine 50mg capsule, take 1 capsule PO every night at bedtime; -divalproex 250mg ER tablet, give two tablets (500mg) PO every night at bedtime; -glipizide 10mg tablet, take one tablet PO twice a day before meals (take 30 minutes before the meal); -hydroxyzine 50mg capsule, take one capsule PO twice a day PRN; -Metformin 1000mg tablet, take one tablet PO twice a day with meals; -metoprolol succinate 25mg extended release (ER) tablet, take one tablet PO daily, take blood pressure before giving, do not give if SBP (systolic) is below 100 and if pulse is below 60; -nicotine gum 4mg, use one piece of gum every	01820			

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01820	Continued From page 64 hour while awake PRN for nicotine craving; -rosuvastatin 5mg tablet, take one tablet (5mg) PO at bedtime; -sitagliptin 50mg, give 50mg PO daily; -tizanidine 4mg tablet, take one tablet PO every six hours PRN for muscle spasms; -trazodone 100mg tablet, take one tablet PO at bedtime PRN for sleep; -Trulicity 1.5/0.5 injection, inject every Wednesday subcutaneously (SQ); -Tylenol 500mg tablet, take two tablets PO every six hours PRN; -Urea 40% cream, self-administer to affected areas on feet twice daily; -Ventolin HFA Aerosol inhaler, inhale two puffs PO four times a day PRN; and -Vraylar 1.5mg capsule, take 1 capsule (1.5mg) by mouth daily at bedtime. R3 R3's Service Plan dated December 28, 2022, indicated R3 received medication management services. R3's record included three After Visit Summary's (AVS) which lacked orders both signed and dated by R3's provider. -AVS June 12-19, 2023, contained a medication print out of known home medications but lacked prescriber's signature; -AVS dated June 22, 2023, contained a medication print out of known home medications but lacked prescriber's signature; and -AVS dated August 25, 2023, contained a medication print out of known home medications. The AVS lacked a prescriber's signature to authenticate the medication list and included a statement, "Always use your most recent med list. Please let us know if anything is missing including supplements or other medications."	01820			

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01820	Continued From page 65 R3's record included an AVS Transfer Orders form dated June, 12, 2023, with signed, but undated, orders to include the following medications: -clozapine 25mg disintegrating tablet, dissolve seven tablets (175mg) PO daily at noon for 14 days; -naloxone 4mg/0.1 milliliters (ml) nasal spray, for suspected overdose, insert tip of the nozzle into one nostril and press plunger firmly to give the dose, call 911, repeat on opposite nostril in three minutes if no or minimal response; -olanzapine, take one tablet (5mg) PO three times daily PRN for agitation; -polyethylene glycol 3350 17 grams (g) powder, mix 17g in four ounces (oz) of a beverage and drink daily as directed; -prazosin 1mg capsule, take one capsule (1mg) PO every evening; and -valacyclovir 500mg, take one tablet (500mg) PO for genital herpes. R3's MAR for October 2023, indicated the licensee was administering the following medications to R3: -acetaminophen 325-650mg PO every four hours PRN for pain/fever; -aluminum hydroxide/magnesium hydroxide/simethicone, take 15ml PO every four hours PRN for upset stomach; -calcium carbonate, 500-100mg (1-2) tablets PO every hour PRN for acid indigestion; -clozapine 200mg, take one tablet (200mg) PO daily; -dextromethorphan guaifenesin, take 10ml PO every four hours PRN for cough; -diphenhist 25mg capsule, take one to two capsules (25-50mg) PO every six hours; -ibuprofen, take 200-400mg PO every six hours	01820			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/01/2023
NAME OF PROVIDER OR SUPPLIER ABRAHAM'S BOSOM CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 437 TOWER STREET SAINT PAUL, MN 55119			
(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 66 PRN for fever or pain; -magnesium hydroxide, take 30-60ml daily PRN for constipation; -olanzapine, take one tablet (5mg) PO three times daily PRN for agitation; -prazosin hydrochloride (HCL) 1mg capsule, take one capsule PO every evening; -Valacyclovir 500mg tablet, take one tablet (500mg) PO at bedtime; On October 31, 2023, at 10:45 a.m., the surveyor showed R2's AVS's to licensed assisted living director (LALD/RN)-A who stated those must have been R2's current orders. The surveyor explained they were not signed by a prescriber. LALD/RN-A stated they were unaware the AVS's were not signed. R3's orders were requested by the surveyor. On October 31, 2023, at 12:48 p.m., LALD/RN-A stated both R2 and R3's orders should be located in their hard charts (paper records). The surveyor explained multiple AVS's were located for both R2 and R3 but lacked prescriber's signatures. On November 1, 2023, at 1:20 p.m., LALD/RN-A stated they had provided the surveyor with all of the medication order documentation they had for R2 and R3. LALD/RN-A stated both nurses, LALD/RN-A and RN-F, were responsible for completing medication reconciliations when new AVS's were sent home with a resident. LALD/RN-A stated it could be challenging to make sure all of the medications had signed orders since residents could have multiple providers involved in their care. LALD/RN-A stated it was expected their own nursing staff would contact the resident's primary provider after all provider visits to verify new AVS medication orders. LALD/RN-A stated no follow up was	01820			

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01820	Continued From page 67 completed by either nurse for any of R2 and R3's AVS's. LALD/RN-A stated they were not notified of the majority of the new AVS's. They stated no follow up was completed for the majority of the AVS's and could not be sure if either resident's medication orders were accurate. The licensee's 7.20 Medication & Treatment Orders policy dated June 1, 2022, indicated: "1) The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. 5) The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed.	01820			

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01820	Continued From page 68 6) The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. 7) The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. 8) A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for three of three residents (R2, R3, R4) with refrigerated medications. In addition, the licensee failed to lock the medication refrigerator to prevent unauthorized access to refrigerated medications by all residents and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880			

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01880	Continued From page 69 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, at 10:45 a.m., the surveyor observed the licensee's medication refrigerator located in the basement with licensed assisted living director/registered nurse (LALD/RN)-A. The medication refrigerator temperature was 33 degrees Fahrenheit (F) during the observation. The medication refrigerator was not behind a locked door and did not have a lock on the refrigerator itself. It contained two 500 milliliter (ml) bottles of Great Value drinking water, a 12 ounce (oz) can of Pepsi, a 24oz bottle of Hershey's chocolate syrup and resident medication. LALD/RN-A stated the nursing staff oversaw reviewing the medication refrigerator on a weekly basis. They stated it was their only medication refrigerator. On October 31, 2023, at 2:00 p.m., the surveyor observed the licensee's medication refrigerator with LALD/RN-A, the temperature was 36.9 degrees F during observation. LALD/RN-A stated the beverages and chocolate syrup in the refrigerator belonged to staff members and were observed by the surveyor to still be in the refrigerator. The Refrigerator Temperature Log included temperatures for all four refrigerators in the facility and indicated the temperature should range between 32 degrees F and 40 degrees F. It indicated documentation of date, time, location, temperature, corrective action, and employee initials. The Refrigerator Temperature Log dates	01880			

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01880	Continued From page 70 ranged from September 13, 2023, to October 29, 2023, and indicated the following medication refrigerator temperatures were outside of temperature parameters: -September 27, 2023, 43.7 degrees F, corrective action "regulated". The Refrigerator Temperature Log form was used to track refrigerator temperatures for multiple refrigerators in the facility. Entries on the log included handwritten refrigerator descriptions by the staff member taking the temperature reading. The form did not always identify which refrigerator was which. The surveyor was only able to determine the medication refrigerator temperature had been checked on the following dates: -September 13-16, 27, 29, 2023; and -October 2, 4, 13, 18, 25, 27, 2023. On October 31, 2023, at 2:00 p.m., the surveyor observed the following medication in the medication refrigerator: -R2 Trulicity four single dose pens, 1.5/0.5ml subcutaneously (SQ) once weekly, expiration July 19, 2025; -R2 Bydureon BCise 2 milligram (mg) single dose autoinjector, inject 0.85ml (2mg) SQ once weekly; -R2 Victoza 18mg/3ml injection, seven boxes inject 0.6mg SQ once daily, various expiration dates but none were expired, one of the boxes was saturated in brown liquid stains; -R3 Ozempic injection pens, one boxes, inject 0.5mg SQ once a week; expiration June 30, 2025; and -R4 Ozempic injection pens, one boxes, inject 0.5mg SQ once a week; expiration June 30, 2025. On November 1, 2023, at 1:20 p.m., LALD/RN-A	01880			

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01880	Continued From page 71 stated anyone could review the medication refrigerator temperature and communicate to the nurse if there were a temperature problem. LALD/RN-A stated the temperature should be checked daily. They acknowledged the Refrigerator Temperature Log was difficult to decipher and was missing documentation. The surveyor pointed out the Refrigerator Temperature Log had a temperature range of 32 degrees F and 40 degrees F and the medications in the medication refrigerator required a higher storage temperature range and would need to be discarded if frozen. LALD/RN-A stated they had not been checking storage temperatures for the medication stored in the refrigerator but did not have an explanation why. LALD/RN-A stated they were aware staff items should not be stored in the medication refrigerator and would address the issue immediately. LALD/RN-A stated they were aware the medication refrigerator needed to be locked and ordered one on Amazon two days ago. LALD/RN-A did not have an explanation as to why there wasn't a lock on the medication refrigerator. Manufacturer directions for Trulicity dated September 2020, indicated to store your Pen in the refrigerator between 36°F to 46°F (2°C to 8°C). Do not freeze your Pen, throw away if it has been frozen and use a new Pen. Manufacturer directions, provided on the box in the facilities refrigerator, indicated Bydureon BCise should be stored FLAT in a refrigerator 36°F to 46°F. Manufacturer directions for Victoza dated January 2010, indicated to store your new, unused Victoza pen in the refrigerator at 36°F to 46°F. Do not freeze Victoza or use if it has been frozen.	01880			

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01880	Continued From page 72 Manufacturer directions for Ozempic injection pens dated September 2023, indicated to store unused pens in the refrigerator at 36°F to 46°F. Do not freeze Ozempic or use if it has been frozen. The licensee's 7.11 Medication Storage policy dated June 1, 2022, indicated, "Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." The policy did not address refrigerator temperature. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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,	01910			

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01910	Continued From page 73 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 the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition of medication 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was discharged from the licensee on November 1, 2022. R1's most recent Assessment dated September 16, 2022, indicated R1 received services for medication management for the following medications: - Fluoxetine 40mg daily-depression; - Quetiapine Fumarate 100mg daily in the morning daily; - Quetiapine Fumarate 200mg daily in the evening; - Ziprasidone 60 mg one capsule twice daily;	01910			

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01910	Continued From page 74 and - Hydroxyzine 25mg by mouth as needed twice daily. R1's record lacked evidence of documented disposition of medications for R1 to include the name of the medication, strength, prescription number (if applicable), quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On October 31, 2023, at 9:00 a.m., LALD/RN-A, stated they sent the medications home with R1 but were not sure where it had been documented, "maybe in his discharge summary." On October 31, 2023, 10:40 a.m., LALD/RN-A stated they could do not find documentation for R1's medication deposition. On October 31, 2023, 11:27 a.m., LALD/RN-A provided a discharge summary for R1. The document did not have a date as to when it was completed. LALD/RN-A stated it was completed when R1 was discharged. LALD/RN-A acknowledged the document was not dated. LALD/RN-A stated the discharge summary did not have a medication disposition for R1. The licensee's 7.23 Medication Disposal policy dated June 1, 2022, indicated, "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." No further information was provided.	01910			

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01910	Continued From page 75 TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



Minnesota Department of Health

625 Robert St N
St. Paul
55155

Type: Full
Date: 10/30/23
Time: 11:30:00
Report: 1043231093

Food and Beverage Establishment Inspection Report

Page 1

Location:

Abraham's Bosom Care Llc
437 Tower Street
St Paul, MN55119
Ramsey County, 62

Establishment Info:

ID #: 0037766
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514289170
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

4-302.13B

**** 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 TEST KIT AVAILABLE. PROVIDE DISPOSABLE TEMPERATURE STRIPS/LABELS OR A MAXIMUM REGISTERING THERMOMETER TO ENSURE DISHES ARE REACHING AT LEAST 160F. COMPLY WITH ABOVE RULE.

Comply By: 10/30/23

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: CHEESE

Temperature: 45 Degrees Fahrenheit - Location: COOLER - COOLING FROM AMBIENT <1HR
Violation Issued: No

Process/Item: LETTUCE

Temperature: 45 Degrees Fahrenheit - Location: COOLER - COOLING FROM AMBIENT <1HR
Violation Issued: No

Process/Item: CREAM CHEESE

Temperature: 45 Degrees Fahrenheit - Location: COOLER - COOLING FROM AMBIENT <1HR
Violation Issued: No

Type: Full
Date: 10/30/23
Time: 11:30:00
Report: 1043231093
Abraham's Bosom Care Llc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: PICKLE

Temperature: 45 Degrees Fahrenheit - Location: COOLER - COOLING FROM AMBIENT <1HR

Violation Issued: No

Process/Item: AMBIENT

Temperature: 38 Degrees Fahrenheit - Location: COOLER

Violation Issued: No

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

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

Facility currently has four residents with a max of five.

This facility has a residential kitchen and equipment. The kitchen finishes and surfaces are well maintained.

Facility serves same day service food, no leftovers are kept.

Dish machine was run with inspector's thermolabel while on site. J. Keen provided temperature results via email.

Discussed highly susceptible populations, cooking temperatures, cold holding, clean up procedures, sanitizer, illness policy, and food storage.

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 1043231093 of 10/30/23.

Certified Food Protection Manager: Adolphia Wolfe

Certification Number: FM110412 Expires: 11/09/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Adolphia Wolfe
Person in Charge

Signed: 

Blia Lor
Public Health Sanitarian I
OLF
651-231-7981
blia.lor@state.mn.us