Electronically Delivered

March 28, 2025

Licensee
Estherra Care LLC
7357 Chowen Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL34157015

Dear Licensee:

On February 25, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine the correction of orders from the survey completed on August 21, 2024, and the follow-up survey completed on November 8, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 29, 2025

Licensee
Estherra Care LLC
7357 Chowen Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL34157015

Dear Licensee:

On November 8, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 8, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 8, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 8, 2024, found not corrected at the time of the November 8, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on November 8, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

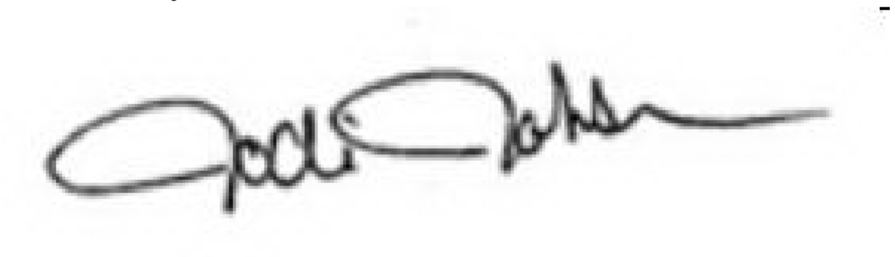
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Estherra Care LLC. Please contact **Bob Dehler at 651-201-3710 on or before Monday, February 3, 2025, to schedule the conference call.**

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34157	A. BUILDING: _____ B. WING _____	R 11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERRA CARE LLC	7357 CHOWEN AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL34157015015-1 On November 8, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on order(s) issued pursuant to a survey completed on August 21, 2024. As a result of the revisit, the following order(s) were reissued and/or issued.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	{0 480}		

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{0 480}	Continued From page 1 one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	{0 480}		

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{0 480}	Continued From page 2 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Not reviewed at this time.	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses 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:	{0 680}		

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{0 680}	Continued From page 3 Not reviewed at this time.	{0 680}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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: Not reviewed at this time.	{0 780}		
{0 800} SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	{0 800}		

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{0 800}	Continued From page 4 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: Not reviewed at this time.	{0 800}		
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress in the upper-level occupied resident bedrooms 4 and 5, and	{0 820}		

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{0 820}	Continued From page 5 unoccupied resident bedroom 3. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 8, 2024, survey staff conducted a revisit to follow up on orders issued by a survey completed on August 21, 2024. On November 8, 2024, at approximately 10:30 to 11:00 a.m., survey staff toured the home with the unlicensed personnel (ULP)-D. During the tour of the upper-level bedrooms, survey staff observed that the non-compliant windows in upper-level resident bedrooms 3, 4, and 5 had not yet been replaced. The ULP-D immediately placed a telephone call to the licensed assisted living director (LALD)-A and the LALD-A stated the new bedroom windows for bedrooms 3, 4, and 5 had not been replaced yet. The LALD-A explained the new windows had been delivered and should be on site and installed soon. Survey staff requested and the LALD-A emailed a copy of the purchase receipt. The LALD-A and the ULP-D verbally confirmed the findings. At approximately 11:15 a.m., survey staff and the ULP-D located three new encasement-type windows on the floor in the back of the garage.	{0 820}		

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{0 820}	Continued From page 6 On November 8, 2024, at approximately noon, during the teleconference interview with the LALD-A, survey staff explained the above findings to the LALD-A and a citation will be re-issued. Survey staff explained to the LALD-A that the 30-minute fire watch must be continued for the non-compliant windows for the occupied bedrooms. The LALD-A acknowledged the findings and stated the bedroom windows will be installed in the next couple of weeks. No further information was provided.	{0 820}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	{01060}		

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{01060}	Continued From page 7 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Not reviewed at this time.	{01060}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	{01760}		

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{01760}	Continued From page 8 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Not reviewed at this time.	{01760}		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Not reviewed at this time.	{01890}		

Electronically Delivered

September 25, 2024

Licensee
Estherra Care LLC
7357 Chowen Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL34157015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 21, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#34157015-0 On August 19, 2024, through August 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; all three were receiving services under the Assisted Living license. 0820: An immediate order was identified on August 21, 2024, at a level 3/Widepsread (I). The immediacy was lifted on August 22, 2024; however, the deficiency remains at a scope/level of I	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34157	A. BUILDING: _____ B. WING _____	08/21/2024

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0 680	Continued From page 2 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct two full scale drills in the last year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 August 21, 2024, at 10:47 a.m. licensed assisted living director/registered nurse	0 680		

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0 680	Continued From page 3 (LALD/RN)-A stated the facility had last conducted table top exercises to test the facility's emergency preparedness program on March 25, 2024; however, no full scale drills or tapletop exercises had been conducted in the last year. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=E	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;	0 780		

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0 780	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect the resident on the lower-level floor and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 21, 2024, from 1:30 p.m. to 2:20 p.m., survey staff toured the home with the licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, survey staff observed the required smoke alarms in the home were not interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout as required. The deficient finding was evident when inside the lower-level resident sleeping room 6 and on the lower-level hallway, the smoke alarms were tested and sounded locally, and failed to actuation the other smoke alarms on the other floors. The above deficient findings were verified by the LALD/RN-A at the time of discovery	0 780		

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0 780	Continued From page 5 accompanying the home tour. On August 21, 2024, at approximately 4:00 p.m., during the exit interview, survey staff explained the above deficient findings to the LALD/RN-A. LALD/RN-A understood and acknowledged the finding and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	0 800		

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0 800	Continued From page 6 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 August 21, 2024, from 1:30 p.m. to 2:20 p.m., survey staff toured the home with licensed assisted living director/registered nurse (LALD/RN)-A. During the home tour, survey staff observed the electrical panel (secured) located inside a resident sleeping room 6 on the lower-level floor, preventing immediate and staff-ready access to the panel during an emergency. Survey staff explained to LALD/RN-A that the electrical must be available for staff-ready access at all hours of the day including evening hours for emergency access. The above deficient finding was verbally and visually verified by LALD/RN-A at the time of discovery. LALD/RN-A stated that she had been trying to relocate the resident to the bedroom on the main floor. On August 21, 2024, at approximately 4:00 p.m., during the exit interview, the survey staff explained the above deficient finding to LALD/RN-A. LALD/RN-A understood and acknowledged the finding and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	0 820		

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0 820	Continued From page 7 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide the minimum state standard-sized egress windows for occupied resident sleeping rooms 4 and 5, and unoccupied resident room 3. This has the potential to directly affect the health, safety, and well-being 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 August 21, 2024, from 1:30 p.m. to 2:20 p.m., survey staff toured the home with licensed	0 820		

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0 820	Continued From page 8 assisted living director/registered nurse (LALD/RN)-A. During the home tour, survey staff observed the following: -The upper-level resident sleeping rooms 4 and 5 did not have windows that met the minimum state standard-sized window requirement for safe egress. The sleeping rooms were occupied by residents. The dimensions of the clear opening double-hung windows in rooms 4 and 5 measured at a width of 35.25 inches and a height of 15 inches and did not meet the state standard-sized window for safe egress in a sleeping room with the required minimum width and height of no less than 20 inches of clear opening and a minimum total open area of 648 square inches for safe egress. TIME PERIOD FOR CORRECTION: Immediate -The upper-level resident sleeping rooms 3 did not have windows that met the minimum state standard-sized window requirement for safe egress. The sleeping room was not occupied by residents. The dimensions of the clear opening of the double-hung windows in rooms 3 measured at a width of 35.25 inches and a height of 15.5 inches and did not meet the state standard-sized window for safe egress in a sleeping room with the required minimum width and height of no less than 20 inches of clear opening and a minimum total open area of 648 square inches for safe egress. TIME PERIOD FOR CORRECTION: 2 days The above deficient findings were verbally and visually verified with LALD/RN-A at the time of discovery. LALD/RN-A stated they have ordered windows for replacements and started	0 820		

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0 820	Continued From page 9 implementing a two-hour fire safety watch plan for the noncomplying egress windows in rooms 3, 4, and 5 to keep residents safe. On August 21, 2024, at 3:30 p.m., survey staff explained to LALD/RN-A that the two-hour fire safety watch plan is not sufficient to lift the immediacy for noncomplying windows in occupied resident rooms 4 and 5, and the issuance of an immediate correction order remains for the deficient findings in occupied resident sleeping rooms 4 and 5. Survey staff further explained that LALD/RN-A proposed a new plan of correction for the immediate order be developed and submitted for approval to lift the immediacy. LALD/RN-A understood and acknowledged the findings. No further information was provided.	0 820		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;	01060		

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01060	Continued From page 10 (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content, to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R1). In addition, the licensee failed to notify the Office of Ombudsman for Long-Term Care of the relocation within four days as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01060		

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01060	Continued From page 11 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's progress notes indicated the following: - R1 was hospitalized December 23, 2023, through January 5, 2024. - R1 was hospitalized February 29, 2024, through March 15, 2024. - R1 was sent to the emergency room on August 16, 2024, and returned to the facility on August 17, 2024. The progress notes included an entry on August 16, 2024, that identified: the date of the emergency relocation, the name of the hospital, the reason for the relocation, contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and a statement that if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal and the contact information to appeal. It failed to include the contact information for the location the resident had been relocated to and the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. The progress notes indicated the mental health case manager, guardian and resident were in agreement with the transfer; however, the documentation lacked evidence the emergency transfer notice had been provided to the resident, the resident, legal representative, designated representative or the case manager.	01060		

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	34157	A. BUILDING: _____ B. WING _____	08/21/2024

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01060	Continued From page 12 On August 20, 2024, at 12:50 p.m. clinical nurse supervisor (CNS)-C stated she was unaware of the emergency transfer requirements until another survey at another facility in June 2024. The facility had a plan to complete it going forward; however, CNS-C was unaware a written notice was required to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of three residents (R1). This practice resulted in a level two violation (a	01760		

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	34157	A. BUILDING: _____ B. WING _____	08/21/2024

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01760	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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's service plan dated March 1, 2024, indicated R1 received medication administration services. R1's medication administration record (MAR) dated August 1-20, 2024, identified Admelog insulin inject 3 units subcutaneously with noon meal, 12 units with evening meal, and 0 units at bedtime as directed. R1's physician order dated February 6, 2024, identified an order for Novolog inject 3 units subcutaneously with noon meal, 12 units with evening meal and 0 units at bedtime. May substitute Admelog depending on insurance coverage. On August 20, 2024, at 11:30 a.m. unlicensed personnel (ULP)-D checked R1's blood glucose and stated the blood glucose result was 118, so R1 did not get any insulin. R1 left the facility for an outing. The surveyor asked ULP-D to review the MAR, ULP-D stated she was not aware that the dose was a scheduled dose and at some point she had changed from Novolog to admelog and maybe that is when it became a scheduled dose. ULP-D contacted the staff with R1 and asked them to return to the facility, At 11:50 a.m., R1 returned to the facility. ULP-D told R1 she needed her insulin and R1 refused to take it.	01760		

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	34157	A. BUILDING: _____ B. WING _____	08/21/2024

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01760	Continued From page 14 On August 20, 2024, at 11:50 p.m. clinical nurse supervisor (CNS)-B stated the insulin was a scheduled dose not sliding scale. R1 frequently refused insulin if her blood sugar was lower; however, staff should have offered R1 the insulin dose and then documented as refused if R1 refused it. At 1:18 p.m., CNS-B stated the insulin order change occurred on February 6, 2024, but due to insurance coverage concerns it did not change immediately, and the MAR was updated when the insulin was approved. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated June 1, 2021, identified "A RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 15	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored at the correct temperature per the medication manufacturer recommendations and the licensee failed to ensure medications were stored with the original pharmacy label for the licensee's one resident (R1) receiving insulin. 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 August 19, 2024, at 2:33 p.m. the surveyor observed the facility's medication refrigerator with licensed assisted living director/registered nurse (LALD/RN)-A. Upon opening the refrigerator, the surveyor observed the thermometer read 30 degrees Fahrenheit (F). LALD/RN-A confirmed the temperature and stated it should be over 36 degrees and she would need to adjust the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34157	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERRA CARE LLC	7357 CHOWEN AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 16 settings. The refrigerator contained six basaglar insulin pens and five admelog insulin pens for R1. The licensee's Medication Refrigerator Temperature log for August 1-19, 2024 identified "Check Medication Refrigerator daily -Temp should be {2° Celsius (C) and 8° C {36° F and 46° F) Notify nurse or management if out of range." The log contained results documented three times a day and the temperature ranged 35-38 degrees Fahrenheit with five days dropping below 36 degrees. There was no indication any adjustments had been made or if the nurse was notified. Basaglar insulin prescribing information dated July 2021, indicated unopened insulin pens should be stored at 36-46 degrees Fahrenheit and insulin should never be frozen. Admelog insulin prescribing information dated December 2017, indicated unopened insulin pens should be stored at 36-46 degrees Fahrenheit and insulin should never be frozen. On August 20, 2024, at 7:59 a.m. unlicensed personnel (ULP)-D removed R2's medications from the medication closet. The surveyor observed a basaglar insulin pen and an admelog insulin pen in R2's bin of medications. Neither the basaglar or the admelog insulin pens had a pharmacy label on them. On August 20, 2024, at 1:40 p.m. LALD/RN-A stated the pharmacy labels were on the insulin boxes in the refrigerator. She was unaware the full pharmacy label needs to be on the insulin pens. The licensee's 7.11 Medication Storage policy	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34157	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERRA CARE LLC	7357 CHOWEN AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 17 dated June 1, 2021, identified "Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *08/20/24*
Time: 13:02:26
Report: 1021241233

Food and Beverage Establishment Inspection Report

Location:
Estherra Care Llc
7357 Chowen Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037743
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9526887164
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.

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE BLEACH ON-SITE WAS NOT FOR FOOD CONTACT SURFACES. PROVIDE AN APPROVED BLEACH.

Comply By: 08/21/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

DRIED FOOD DEBRIS WAS FOUND ON THE FOOD THERMOMETER PROBE. DISCUSSED CLEANING AND SANITIZING THE FOOD THERMOMETER PROBE AFTER EACH USE. THE THERMOMETER PROBE WAS CLEANED AND SANITIZED WITH AN ALCOHOL WIPE DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 08/20/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

A CONTAINER OF FLOUR AND A BOTTLE OF OIL WERE FOUND ON THE PANTRY FLOOR. STAFF MOVED THE FOOD ITEMS UP FROM THE FLOOR. CORRECTED ON-SITE.

Comply By: 08/20/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

ACCUMULATION OF GREASE UNDER THE MICROWAVE AND ON THE GREASE FILTER. STAFF CLEANED UNDER THE MICROWAVE AND THE FILTER DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 08/20/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temperature
Temperature: 41 Degrees Fahrenheit - Location: SAMSUNG REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: MILK - SAMSUNG REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: SHREDDED CHEESE - SAMSUNG REFRIGERATOR

Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH LALD, ESTHER WAKO AND HEALTH REGULATION DIVISION NURSE EVALUATOR, STACY HAAG.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH LALD, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, PAINTED DRYWALL AND WOOD FLOORS. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

Type: Full
Date: *08/20/24*
Time: 13:02:26
Report: 1021241233
Estherra Care Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021241233 of 08/20/24.

Certified Food Protection Manager: BOUATHONG THONGSAVANH

Certification Number: FM118402 Expires: 04/24/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
ESTHER WAKO
LALD

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us