DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

April 15, 2025

Licensee
Moonlight Home Health Care LLC
7144 Lake Shore Drive South
Richfield, MN 55423

RE: License Number 416563
Health Facility Identification Number (HFID) 36847
Project Number(s) SL36847015

Dear Licensee:

On March 17, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 15, 2024, and the follow-up survey completed on November 4, 2024. This follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective March 17, 2025.

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.

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,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 17, 2024

Licensee
Moonlight Home Health Care LLC
7144 Lake Shore Drive South
Richfield, MN 55423

RE: Conditional License Number 416563
Health Facility Identification Number (HFID) 36847
Project Number(s) SL36847015

Dear Licensee:

On November 4, 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 August 15, 2024. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a conditional assisted living facility license for 90-days, due to expire on **March 17, 2025**.

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 and immediately correct any reissued orders 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

CONDITIONAL LICENSE ISSUED:
MDH will issue a conditional assisted living facility license for Moonlight Home Health Care LLC, for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Moonlight Home Health Care LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **Health Facility Construction Permit:** Moonlight Home Health Care LLC, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Moonlight Home Health Care LLC, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. **General Contractor:** Moonlight Home Health Care LLC must provide the following to Tim Hanna (Tim.Hanna@state.mn.us) via email within 21-days of the date of this notice:
    i. Name
    ii. License Number
    iii. Contact Information

c. **Egress Window Requirements:** Moonlight Home Health Care LLC will replace at least one window in unoccupied resident sleeping room #1 meeting the minimum size requirements.
    i. Must have a minimum openable width of no less than 20 inches
    ii. Must have a minimum openable height of no less than 20 inches
    iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
    iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
    v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Moonlight Home Health Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Moonlight Home Health Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Moonlight Home Health Care LLC's assisted living facility license, and Moonlight Home Health Care LLC will correct any outstanding violations identified during the survey. If Moonlight Home Health Care LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

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

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

If you have any questions, please contact Jess Schoenecker directly at: 651-201-3789.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36847	A. BUILDING: _____ B. WING _____	R 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOONLIGHT HOME HEALTH CARE LLC	7144 LAKE SHORE DRIVE SOUTH RICHFIELD, MN 55423

(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, 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#36847015-1 On November 4, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 15, 2024. At the time of the survey, there were 2 active residents; 2 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required	{0 110}		

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{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by:	{0 110}	Not reviewed during this survey.	
{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	{0 470}		

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{0 470}	Continued From page 2 (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}	Not reviewed during this survey.	
{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:	{0 480}	Not reviewed during this survey.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}	Not reviewed during this survey.	

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{0 550}	Continued From page 3	{0 550}		
{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:	{0 550}	Not reviewed during this survey.	
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	{0 630}		

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{0 630}	Continued From page 4 self-abuse. This MN Requirement is not met as evidenced by:	{0 630}	Not reviewed during this survey.	
{0 730} SS=D	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 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	{0 730}		

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{0 730}	Continued From page 5 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:	{0 730}	Not reviewed during this survey.	
{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	{0 780}		

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{0 780}	Continued From page 6 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}	Not reviewed during this survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{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	{0 810}		

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{0 810}	Continued From page 7 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be	{0 820}		

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{0 820}	Continued From page 8 permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 November 4, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a follow up survey completed on August 15, 2024. On November 4, 2024, at 10:35 a.m. unlicensed personnel (ULP)-E stated bedroom #1's window has not been replaced since the last follow up	{0 820}		

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{0 820}	Continued From page 9 survey and will be installed sometime next week. On November 4, 2024, at 10:40 a.m. surveyor toured the facility with unlicensed personnel (ULP)-E. During the tour, surveyor asked to open the windows in the resident bedroom #1 for measurement. The noncompliant measurement was as follows: Unoccupied Resident Sleeping Room: Bedroom #1 window measured 23 inches clear width, 20 inches clear height, and 460 square inches total open area per window. The window in bedroom #1 did not meet the minimum requirements for total openable area. Surveyor explained to ULP-E that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. ULP-E verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. During phone interview on November 5, 2024, at 9:39 a.m. licensed assisted living director (LALD)-A stated bedroom #1's window has not been replaced and hopefully the window will be installed this week. No further information was provided.	{0 820}		

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{0 970}	Continued From page 10	{0 970}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}	Not reviewed during this survey.	
{01620} SS=D	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	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36847	A. BUILDING: _____ B. WING _____	R 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOONLIGHT HOME HEALTH CARE LLC	7144 LAKE SHORE DRIVE SOUTH RICHFIELD, MN 55423

(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 11 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01620}	Not reviewed during this survey.	
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	{01730}		

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{01730}	Continued From page 12 (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}	Not reviewed during this survey.	
{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:	{01760}	Not reviewed during this survey.	

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{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	{01820}	Not reviewed during this survey.	

Electronically Delivered

September 18, 2024

Licensee
Moonlight Home Health Care LLC
7144 Lake Shore Drive South
Richfield, MN 55423

RE: Project Number(s) SL36847015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 15, 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 . . ."

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.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36847	A. BUILDING: _____ B. WING _____	08/15/2024

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MOONLIGHT HOME HEALTH CARE LLC	7144 LAKE SHORE DRIVE SOUTH RICHFIELD, MN 55423

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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: SL36847015-0 On August 12, 2024, through August 15, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 13, 2024, issued for SL36847015-0, tag identification 0820. On August 15, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at level 3, isolated (G).	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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record (DOR) for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 13, 2024, at 9:15 a.m., during a follow up entrance conference with licensed assisted living director (LALD)-A, the surveyor reviewed the Board of Executives for Long-term Services and Supports (BELTSS) website with LALD-A. LALD-A's license was current but lacked identification as the DOR for the licensee. The surveyor showed LALD-A on the BELTSS website where the DOR information would be listed once corrected. Further, LALD-A stated she was not aware of the assisted living license requirement to be identified as the DOR for the	0 110		

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0 110	Continued From page 2 licensee in the BELTSS website. On August 15, 2024, at 9:00 a.m., during the exit conference, the surveyor checked the BELTSS website and LALD-A remained unlisted as the DOR for the licensee. LALD-A verbalized she planned to update the DOR in the BELTSS website. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 470		

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0 470	Continued From page 3 facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 August 12, 2024, at 10:30 a.m., the surveyor observed the main areas of the facility with unlicensed personnel (ULP)-C. The surveyor observed a posted "Employee Weekly Schedule" outside the kitchen area in the main living room dated November 7, 2022, through November 13, 2022, which included employee names, shift schedule, and days of the week. The weekly schedule posted was not current to date and did not reflect the current names of employees and daily staffing schedule. -at 10:35 a.m., ULP-C stated yes, the employee	0 470		

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0 470	Continued From page 4 schedule posted at the facility was not a current staffing schedule and ULP-C verbalized she planned to follow up with licensed assisted living director (LALD)-A. On August 13, 2024, at 9:10 a.m., LALD-A stated, the licensee would ensure a current and accurate staff schedule was posted in the main area of the facility. Also, LALD-A stated the employees were trained to post the staffing schedule weekly on Mondays, but they must have posted the wrong schedule. The licensee's Staffing policy dated July 24, 2023, included "7. The schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public." 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 ensure food was prepared and served according to the Minnesota Food Code.	0 480		

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0 480	Continued From page 5 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 12, 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		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to	0 510		

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0 510	Continued From page 6 comply with accepted health care, medical, and nursing standards for infection control when the licensee failed to ensure direct care staff performed adequate hand hygiene (HH), glove use, and disinfection of surfaces for one of two 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 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: ULP-C was hired on June 1, 2021, and provided direct care services to the licensee's residents. On August 12, 2024, at 11:30 a.m., with permission from R2, the surveyor observed unlicensed personnel (ULP)-C to assist R2's with blood glucose testing. First, ULP-C donned (applied) gloves, unlocked the locked medication closet located in the hallway to kitchen area, obtained R2's blood glucose testing supplies and completed blood glucose testing for R2. Next, with gloves still donned, returned blood glucose testing supplies in the medication closet, grabbed R2's medical record binder located on the top shelf of the medication closet, closed and locked the door. Then, ULP-C without doffing (removing) her gloves proceeded to touch the kitchen counter, the front of the refrigerator, and carried R2's medical record binder to the dining room table. ULP-C did not complete hand hygiene and gloving procedure, prior to or after assisting R2	0 510		

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0 510	Continued From page 7 with blood glucose testing. In addition, ULP-C failed to disinfect the surface of the preparation area before or after completing R2's blood glucose testing. -at 11:40 a.m., ULP-C stated HH, glove use, and infection control training was provided by a nurse upon hire. Also, ULP-C verbalized she also completed infection control training on the licensee's online education program when she was hired and annually. ULP-C stated she was nervous during the surveyor's observation and should have completed hand hygiene before and after R2's blood glucose testing. Further, ULP-C stated she should have doffed her gloves and completed HH immediately after she completed R2's blood glucose testing. ULP-C agreed she should have disinfected the preparation area before and after she completed R2's blood glucose testing. -12:40 p.m., clinical nurse supervisor (CNS)-B stated the employees were trained to complete HH before and after completing blood glucose testing, gloves changes, as well as at other points during clinical cares. Also, CNS-B verbalized training was completed upon hire and annually with all employees. The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, indicated, standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices	0 510		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 8 c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." Also, included environmental cleaning and disinfection and noted "Require routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling. Clean and disinfect surfaces in close proximity to the patient and frequently touched surfaces in the patient care environment on a more frequent schedule compared to other surfaces. Promptly clean and decontaminate spills of blood or other potentially infectious materials." The licensee's undated Infection Control/CDC Standards policy included "Procedure: Standard Precautions: Standard precautions apply to blood, all body fluids, secretions, excretions, non-intact skin, and mucous membranes. All are to be treated as a potential source of infection regardless of whether the client has a communicable disease. -Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganism between client or the environment -Gloves are worn when touching blood, body fluids, secretions, excretions non-intact skin, mucous membranes, or contaminated items." Also, indicated "Hands should be washed at the following times: 1. After changing beds 2. Before assisting with medications	0 510		

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	36847	A. BUILDING: _____ B. WING _____	08/15/2024

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0 510	Continued From page 9 3. Before and after treatments 4. After all pet care 5. After housekeeping 6. After emptying bedpans 7. After assisting the client to the toilet 8. After removing items from the floor 9. Before preparing food 10. Before feeding clients 11. After using bathroom 12. After coughing or sneezing 13. After smoking 14. After handling plants 15. After removing gloves No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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.	0 550		

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0 550	Continued From page 10 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, including the name, and the telephone numbers for the individuals who are responsible for handling resident grievances. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During a facility tour on August 12, 2024, at 10:14 a.m., the surveyor observed the common areas shared by residents, staff, and visitors lacked the required posting of a grievance procedure to include the name, and telephone numbers for the individuals who were responsible for handling resident grievances. On August 13, 2024, at approximately 9:25 a.m., licensed assisted living director (LALD)-A acknowledged the grievance procedure with required content was not posted in the common areas. LALD-A stated she realized the contact's name and telephone numbers for individuals who are responsible for handling resident grievances was not current. Also, LALD-A verbalized the	0 550		

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0 550	Continued From page 11 person listed was no longer employed by the licensee. Further, LALD-A updated the contact information during the survey and LALD-A posted in the main area of the facility. The licensee's Grievance policy dated May 30, 2023, indicated "2. A copy of the grievance procedure is conspicuously posted in the residence with the following information: -Name, phone number and email contact information for the individuals who are responsible for handling resident complaints." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an accurate individual abuse prevention plan (IAPP) with the required	0 630		

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0 630	Continued From page 12 content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted January 25, 2024, and had diagnoses including diabetes mellitus (type 2, insulin dependent), schizophrenia (a mental health disorder that affects how people think, feel, and behave), and epilepsy (a seizure disorder). R2's service plan dated January 25, 2024, indicated R2 received services including assistance with housekeeping, meals, laundry, toileting, grooming, blood glucose monitoring, and medication administration. R2's medical record included a Vulnerability Assessment dated January 25, 2024, which instructed the licensee to complete a specific plan for all areas marked, "Yes." R2's vulnerability assessment lacked - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On August 13, 2024, at 4:26 p.m., clinical nurse supervisor (CNS)-B confirmed R3's IAPP did not address the above noted areas of risk or include statements of specific measures to be taken to	0 630		

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0 630	Continued From page 13 minimize risks. CNS-B stated she was not aware of the required specific interventions to minimize the risk of vulnerabilities assessed on the IAPP's. Also, CNS-B verbalized it will be helpful when the licensee implements a planned new electronic medical record to ensure the IAPP's include the required content. The licensee's undated Vulnerable Adult/Child Protection policy indicated on page seven, "An individual abuse prevention plan shall be established for each vulnerable minor or adult for whom home care services are provided. 1. The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults/minors." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=D	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	0 730		

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

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0 730	Continued From page 15 resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 13, 2024, at 9:40 a.m., licensed assisted living director (LALD)-A provided R2's requested medical record. LALD-A verbalized the licensee currently utilized paper documentation for the residents' medical records and the licensee planned to implement a new electronic medical record program soon. R2 was admitted January 25, 2024, and had diagnoses including diabetes mellitus (type 2, insulin dependent), schizophrenia (a mental health disorder that affects how people think, feel, and behave), and epilepsy (a seizure disorder). R2's service plan dated January 25, 2024, indicated R2 received services including assistance with housekeeping, meals, laundry, toileting, grooming, blood glucose monitoring, and medication administration. R2's medical record included documents titled "Treatment Management, Daily Resident Log", and medication administration records (MAR's) which lacked the following required content: -treatment management plan lacks authentication	0 730		

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0 730	Continued From page 16 by the registered nurse (RN); -daily resident logs were missing notation of the resident's name, month, or year for documentation of residents' daily services provided by the licensee; and -medication administration record (MAR's) were missing notation of the month and year for medication administration documentation. On August 13, 2024, at 11:15 a.m., LALD-A acknowledged R2's daily documentation logs and medication administration records were not completed with the required information. Also, LALD-A verbalized the employee's must have missed documenting these required items on R2's paper medical records. Further, LALD-A stated the licensee planned to transition to a new electronic medical record system soon. The licensee's undated Residents Records policy did not include information on the required residents record information to be kept in the resident's medical record. Instead, the policy indicated "When a resident is discharged to another facility, the [licensee] will convey the health history and client information to the new facility or provider within 48 hours of discharge." 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:	0 780		

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0 780	Continued From page 17 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 780		

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0 780	Continued From page 18 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 13, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the facility tour, it was observed that smoke alarms in the sleeping room and immediately outside the sleeping room on the lower level were not interconnected with the rest of the smoke alarms in the facility, so the actuation of that alarm would cause all alarms to operate. During the interview on August 13, 2024, at 11:00 a.m., LALD-A stated that one type of smoke alarm was installed and interconnected on the main level, and the other type was installed on the lower level and not interconnected. This deficient condition was verified by LALD-A accompanying the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 13, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: On the concrete stoop and steps outside the main entrance door, it was observed that the installed floor-mounted guards were loose and were not securely mounted to the floor. In the bathroom on the lower level, it was observed that the ceiling light was missing the fixture cover. It was also observed there were brown stains on the gypsum ceiling, with evidence of water leakage from the pipe above. In the bathroom on the main level, it was observed that the ceiling finish was bubbled, and the paint was cracked.	0 800		

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0 800	Continued From page 20 During the facility tour at 10:00 a.m., LALD-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 21 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 13, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. The FSEP and posted evacuation plan did not show the location and number of resident rooms. During the tour on August 13, 2024, at 10:00 a.m., with LALD-A, it was observed that the	0 810		

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0 810	Continued From page 22 posted FSEPs were not accurate depictions of the egress route and were not matched to the current layout of the facility. The posted evacuation plan did not identify egress routes and emergency exits from the lower level, and the egress stair and closet locations were not shown correctly on the lower level. During the interview on August 13, 2024, at 11:30 a.m., LALD-A verified the facility needed to update the fire safety and evacuation plan with the location and number of resident rooms. DRILLS Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift as required by statute. Provided documentation indicated drills were conducted for the first and second shifts, and the facility failed to provide two drills for the third shift. During the interview on August 13, 2024, at 11:30 a.m., LALD-A stated the drills were conducted at 2 p.m. or 3 p.m. and did not provide the required drills for the night shift. LALD-A verified there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	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	0 820		

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MOONLIGHT HOME HEALTH CARE LLC	7144 LAKE SHORE DRIVE SOUTH RICHFIELD, MN 55423

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0 820	Continued From page 23 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 a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom 1 on the main level. 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 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 August 13, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following items:	0 820	This immediate correction order identified on August 13, 2024, has had the immediacy lifted as of August 15, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 24 It was observed that occupied resident bedroom 1 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 20 inches in height and 23 inches in width, with a total openable area of 460 square inches. The windows did not meet the minimum requirements for a total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. On August 13, 2024, at 11:00 a.m., during the interview, survey staff explained to LALD-A that an immediate correction order was issued for the above finding. LALD-A acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On August 15, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at and scope and level of G.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	0 970		

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0 970	Continued From page 25 liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted January 25, 2024, and had diagnoses including diabetes mellitus (type 2, insulin dependent), schizophrenia (a mental health disorder that affects how people think, feel, and behave), and epilepsy (a seizure disorder). R2's service plan dated January 25, 2024, indicated R2 received services including	0 970		

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0 970	Continued From page 26 assistance with housekeeping, meals, laundry, toileting, grooming, blood glucose monitoring, and medication administration. R3 R3 was admitted August 30, 2023, and had diagnoses including schizoaffective disorder (a mental health disorder characterized by abnormal thought processes and an unstable mood). R3's service plan dated August 30, 2023, indicated R3 received services including assistance with meals, laundry, toileting, grooming, vital signs, and medication administration. R2 and R3's signed Assisted Living Contracts dated January 25, 2024, and August 30, 2023, respectively, included the following language indicating a waiver of liability: Miscellaneous Provisions: 1. Insurance Liability and Release. "The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its	0 970		

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0 970	Continued From page 27 employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee] or its employees or agents." On August 13, 2024, at 9:25 a.m., licensed assisted living director (LALD)-A stated she was not aware of the specific restriction on waivers of liability but did understand after the surveyor referred to the licensee's assisted living contract and statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01620 SS=D	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	01620		

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01620	Continued From page 28 the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after start of services for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 12, 2024, at 11:30 a.m., the surveyor observed unlicensed personnel (ULP)-C to assist R2 with blood glucose testing. On August 12, 2024, at 11:50 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee completed assessments upon admission, at 14 days, every 90 days, and with changes in condition.	01620		

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01620	Continued From page 29 R2 was admitted January 25, 2024, and had diagnoses including diabetes mellitus (type 2, insulin dependent), schizophrenia (a mental health disorder that affects how people think, feel, and behave), and epilepsy (a seizure disorder). R2's service plan dated January 25, 2024, indicated R2 received services including assistance with housekeeping, meals, laundry, toileting, grooming, blood glucose monitoring, and medication administration. R2's medical record included an initial comprehensive nursing assessment, dated January 25, 2024, and a 14-day assessment dated February 13, 2024, 19 days after the initial comprehensive nursing assessment. On August 13, 2024, at 4:26 p.m., CNS-B stated she was aware R2's 14-day assessment was completed late. Also, CNS-B verbalized she had difficulty coordinating a time with R2 to complete the 14-day assessment on time. The licensee's undated Assessment - Comprehensive services policy included "3. The RN will provide a reassessment visit to update the evaluation of the client and services no more than 14 days after initiation of services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 30 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed	01730		

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01730	Continued From page 31 when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop an individualized medication management record with the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On August 12, 2024, at 11:30 a.m., with permission from R2, the surveyor observed unlicensed personnel (ULP)-C to assist R2's with medication administration and blood glucose testing. R2 was admitted January 25, 2024, and had diagnoses including diabetes mellitus (type 2, insulin dependent), schizophrenia (a mental health disorder that affects how people think, feel, and behave), and epilepsy (a seizure disorder). R2's service plan dated January 25, 2024, indicated R2 received services including	01730		

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01730	Continued From page 32 assistance with housekeeping, meals, laundry, toileting, grooming, blood glucose monitoring, and medication administration. R2's medical record included an incomplete, undated Medication Management Plan, which lacked a signature by a registered nurse (RN), and lacked the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and -identification of medication management tasks that may be delegated to unlicensed personnel. On August 13, 2024, at 4:26 p.m., via phone, clinical nurse supervisor (CNS)-B stated the licensee failed to fully complete R2's medication management plan with all the required content. Also, CNS-B stated she was not sure why R2's medication management plan was not dated or signed, and this must have been overlooked. CNS-B stated the licensee would be transitioning to a new electronic medical record system soon. The licensee's Medication Management Program policy, dated 2022, indicated the following services were included in the medication management program: 1. Performing medication set up 2. Administering medications 3. Storing and securing medications; 4. Documenting medication activities;	01730		

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01730	Continued From page 33 5. Verifying and monitoring effectiveness of systems to ensure safe handling and administration; 6. Coordinating refills; 7. Handling and implementing changes to prescriptions; 8. Communicating with the pharmacy about the resident's medications; and 9. Coordinating and communicating with the prescriber." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medications were administered per providers orders and	01760		

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01760	Continued From page 34 manufacturer recommendations for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted January 25, 2024, and had diagnoses including diabetes mellitus (type 2, insulin dependent), schizophrenia (a mental health disorder that affects how people think, feel, and behave), and epilepsy (a seizure disorder). R2's service plan dated January 25, 2024, indicated R2 received services including assistance with housekeeping, meals, laundry, toileting, grooming, blood glucose monitoring, and medication administration. On August 12, 2024, at 11:30 a.m., with permission from R2, the surveyor observed unlicensed personnel (ULP)-C to assist R2's with medication administration and blood glucose testing. On August 12, 2024, at 12:00 p.m., the surveyor requested the provider orders for R2. CNS-B stated the signed "After Visit Summary" dated June 5, 2024, were R2's most current provider orders.	01760		

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01760	Continued From page 35 R2's prescriber orders, dated June 5, 2024, included the following: -acetaminophen (for pain or fever) 325 milligrams (mg), take one to two tablets (325-650 mg) by mouth every four hours as needed; and -fluticasone propionate (for ease of breathing) 50 mcg/actuation (act), Place 1-2 sprays into both nostrils daily. R2's undated medication administration record (MAR) indicated the two following transcription errors when reconciled with the prescriber order: -"acetaminophen 325 mg take 1 tab by mouth as needed for pain"; and -"fluticasone 50 mcg spray 1 to 1 sprays in each nostril daily." During a phone interview on August 14, 2024, at 2:13 p.m., the surveyor reviewed R2's medication orders with CNS-B. CNS-B stated there was a transcription error made with R2's acetaminophen and fluticasone proprionate. The licensee's Medication Management Program policy, dated 2022, indicated admission to the medication management program is at the discretion of the registered nurse (RN) and based on a professional face-to-face nursing assessment that included medication reconciliation, coordination and communication with prescriber and other providers involved with medication management, and handling or implementing changes to prescriptions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01820	Continued From page 36	01820		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure complete written or electronically recorded prescriptions were obtained for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 12, 2024, at 11:50 a.m., clinical nurse supervisor (CNS)-B indicated the licensee provided medication management services for the licensee's residents. R2 was admitted January 25, 2024, and had diagnoses including diabetes mellitus (type 2, insulin dependent), schizophrenia (a mental health disorder that affects how people think, feel, and behave), and epilepsy (a seizure disorder).	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36847	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOONLIGHT HOME HEALTH CARE LLC	7144 LAKE SHORE DRIVE SOUTH RICHFIELD, MN 55423

(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 37 R2's service plan dated January 25, 2024, indicated R2 received services including assistance with housekeeping, meals, laundry, toileting, grooming, blood glucose monitoring, and medication administration. On August 12, 2024, at 11:30 a.m., with permission from R2, the surveyor observed unlicensed personnel (ULP)-C to assist R2's with medication administration and blood glucose testing. On August 12, 2024, at 12:00 p.m., the surveyor requested the provider orders for R2. CNS-B stated the signed "After Visit Summary" dated June 5, 2024, were R2's most current provider orders. R2's After Visit Summary medication list, dated June 5, 2024, included the following: -acetaminophen (for pain or fever) 325 milligrams (mg), take one to two tablets by mouth every four hours as needed; -albuterol sulfate inhaler (for breathing problems) 108 (90 base) micrograms (mcg), inhale one to two puffs every four hours as needed; -diphenhydramine (an antihistamine) 25 mg, take one capsule by mouth; -docusate sodium (for constipation) 100 mg, take one capsule by mouth, twice daily; -famotadine (reduces stomach acid) 20 mg, take one tablet by mouth twice daily as needed; -fluticasone propionate (a steroid for asthma) 50 mcg diskus, inhale one puff two times daily; -folic acid (a supplement) 1 mg, take one tablet by mouth daily; -gabapentin 600 mg (for pain), take one tablet by mouth twice daily (morning and midday) and two	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36847	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOONLIGHT HOME HEALTH CARE LLC	7144 LAKE SHORE DRIVE SOUTH RICHFIELD, MN 55423

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01820	Continued From page 38 tablets at bedtime; -glipizide XL (helps control blood sugar) 10 mg 24-hour release, take one tablet by mouth daily; -ibuprofen (for pain) 200 mg, take one to two tablets by mouth every four hours as needed; -levetiracetam (to treat seizures) 750 mg, take one tablet by mouth twice daily; -lurasidone (to treat mental health disorders) 20 mg, take one tablet by mouth daily; -metformin XR (helps control blood sugar) 500 mg 24-hour release, take two tablets by mouth every evening with meal; -methylcellulose (for constipation) oral powder, take 2 grams (g) by mouth as needed; -naproxen (for pain/inflammation) 500 mg, take one tablet by mouth two times daily as needed; -polyethylene glycol (a laxative) 3350 17 g/scoop powder, take 17 g by mouth daily as needed; -ramelteon (for sleep) 8 mg, take one tablet by mouth at bedtime; -ropinirole (to treat Parkinson's disease and restless leg syndrome) 0.5 mg, take one tablet by mouth twice daily; -rosuvastatin 20 mg, take one tablet by mouth daily; -sennosides-docusate sodium (for constipation) 8.6-50 mg, take one tablet daily as needed; -sertraline (for depression) 50 mg, take one tablet by mouth daily; and -thiamine (a supplement) 100 mg, take one tablet by mouth daily. Review of R2's undated medication administration record (MAR), lacked the following medications, previously listed: -albuterol sulfate HFA 108 (90 Base) micrograms (mcg)/ACT inhaler, inhale one to two puffs every four hours as needed; -diphenhydramine 25 mg, take one capsule by	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36847	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOONLIGHT HOME HEALTH CARE LLC	7144 LAKE SHORE DRIVE SOUTH RICHFIELD, MN 55423

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01820	Continued From page 39 mouth; -famotidine 20 mg, take one tablet by mouth twice daily as needed; -folic acid 1 mg, take one tablet by mouth daily; -ibuprofen 200 mg, take one to two tablets by mouth every four hours as needed; -methylcellulose (for constipation) oral powder, take 2 grams (g) by mouth as needed; -naproxen 500 mg, take one tablet by mouth two times daily as needed; -ramelteon (for sleep) 8 mg, take one tablet by mouth at bedtime; -rosuvastatin 20 mg, take one tablet by mouth daily; and -thiamine 100 mg, take one tablet by mouth daily. During a phone interview on August 14, 2024, at 2:13 p.m., CNS-B stated she reached out to the licensee's pharmacy, during the survey, to receive the discontinued medication orders not found in R2's medical record. Also, CNS-B verbalized R2 transferred from one pharmacy to use the licensee's pharmacy, and the pharmacy was not able to retrieve old, discontinued orders. Further, CNS-B stated she did not have the discontinued prescriber orders for the medications not included on R2's MAR. The licensee's Medication Management Program policy, dated 2022, indicated admission to the medication management program is at the discretion of the registered nurse (RN) and based on a professional face-to-face nursing assessment that included medication reconciliation, coordination and communication with prescriber and other providers involved with medication management, and handling or implementing changes to prescriptions.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOONLIGHT HOME HEALTH CARE LLC	7144 LAKE SHORE DRIVE SOUTH RICHFIELD, MN 55423

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01820	Continued From page 40 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *08/12/24*
Time: 12:33:06
Report: 7994241148

Food and Beverage Establishment Inspection Report

Location:

Moonlight Home Health Care Llc
7144 Lake Shore Drive South
Richfield, MN55423
Hennepin County, 27

Establishment Info:

ID #: 0039131
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6147792751
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS FOUND STORED ON MIDDLE SHELF. MOVE THESE TO LOWEST SHELF.

Comply By: 08/12/24

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

CURRENT THERMOMETER IN THE DISHWASHER WAS FOUND BROKEN. DISCUSSED VARIOUS OPTIONS WITH STAFF.

Comply By: 08/12/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CFPM WAS FOUND ON SITE. PROVIDED CFPM INFO VIA EMAIL.

Comply By: 08/12/24

Type: Full
Date: *08/12/24*
Time: 12:33:06
Report: 7994241148
Moonlight Home Health Care Llc

Food and Beverage Establishment Inspection Report

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS WOOD LAMINATE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND SMOOTH PAINTED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

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 7994241148 of 08/12/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241148

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2	**Date**	08/12/24
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:33:06
Legal Authority MN Rules Chapter 4626		**Time Out**	

Moonlight Home Health Care Llc	**Address** 7144 Lake Shore Drive South	**City/State** Richfield, MN	**Zip Code** 55423	**Telephone** 6147792751
License/Permit # 0039131	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/12/24

Inspector (Signature) Crystal Elva