Electronically Delivered

August 16, 2022

Administrator
Hands Care LLP
1065 Dennis Street South
Maplewood, MN 55119

RE: Project Number(s) SL35315015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 28, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35315	A. BUILDING: _____ B. WING _____	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS CARE LLP	1065 DENNIS STREET SOUTH MAPLEWOOD, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL35315015 On June 27, 2022 through June 28, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one (1) resident receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 120 SS=C	144G.11 APPLICABILITY OF OTHER LAWS	0 120		

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0 120	Continued From page 1 Assisted living facilities: (1) are subject to and must comply with chapter 504B; (2) must comply with section?325F.72; and (3) are not required to obtain a lodging license under chapter 157 and related rules. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an assisted living advertising dementia care had an assisted living dementia care license in place. 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: The facility was licensed as an assisted living facility. Observation of the licensee's website revealed advertisement to provide services for dementia. During the entrance conference on June 27, 2022, at approximately 2:30 p.m. licensed assisted living director (LALD)-A confirmed the facility's website contained advertisement to provide services for dementia. LALD-A stated that the licensee did not have any residents with dementia and LALD-A would remove advertisement for dementia care services from	0 120		

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0 120	Continued From page 2 the website. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 120		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 480		

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0 480	Continued From page 3 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 28, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activities. This had the potential to affect the one (1) resident receiving assisted living services.	0 580		

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0 580	Continued From page 4 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 June 27, 2022, at 2:30 p.m., the surveyor requested the licensee's documentation of any quality management activities. Licensed assisted living director (LALD)-A confirmed the license had no current documentation of quality management activity. The licensee's Quality Management Project policy, dated August 1, 2021, directed the licensee have at least one quality management project in place at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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0 680	Continued From page 5 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect the one resident receiving assisted living services, 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:	0 680		

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0 680	Continued From page 6 During the entrance conference on June 27, 2022, at approximately 2:30 p.m., a request was made to view the licensee's emergency preparedness plan, which was later reviewed by the surveyor. On June 28, 2022, at approximately 10:00 a.m., the licensed assisted living director (LALD)-A provided the licensee's Appendix Z and confirmed the licensee's emergency preparedness plan was not completed. The licensee's plan lacked the following required content: -description of the population served by licensee; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; The licensee's Emergency Preparedness Plan policy, dated June 2021, directed the licensee have in place a general emergency preparedness plan that was in alignment with facility's requirement to also comply with CMS Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 7 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms for resident rooms (#1, #2, # 3, and #4). This has the potential to directly affect the residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	0 780		

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0 780	Continued From page 8 On June 28, 2022, approximately from 1:15 p.m. to 2:45 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed resident rooms #1, #2, #3, and #4 were not provided with smoke alarms as required. The LALD-A verified the findings as she asked if this requirement was part of the new assisted living law. Survey staff further clarified to the LALD-A that all the missing smoke alarms in resident rooms must be interconnected with the existing home smoke alarm system such that when any smoke alarm sounds in the home, all smoke alarms in the home sound for notification. The LALD-A acknowledged the requirement. On June 28, 2022, at approximately 3:10 p.m., during the exit interview, the LALD-A confirmed the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and	0 790		

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0 790	Continued From page 9 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to install and maintain the proper portable fire extinguisher at the facility. 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, but was not likely to cause serious injury, impairment, or death) and 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 June 28, 2022, approximately from 1:15 p.m. to 2:45 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. Survey staff observed and the LALD-A verified the following findings during the home tour: MINIMUM SIZE REQUIRED The portable fire extinguisher did not meet the required minimum rated type, 2-A:10-B:C. Survey staff observed the label on the mounted unit in the kitchen with the incorrect size unit with rating type 1-A:10-B:C. MAINTENANCE/INSPECTIONS The portable fire extinguisher was observed with no tag attached to indicate the required annual	0 790		

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0 790	Continued From page 10 service and monthly inspections from this year, or any previous years. On June 28, 2022, at approximately 3:10 p.m., during the exit interview, the LALD-A acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 800		

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0 800	Continued From page 11 has affected or has the potential to affect a large portion or all of the residents). The findings are: On June 28, 2022, approximately from 1:15 p.m. to 2:45 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. Survey staff observed and the LALD-A verified the following findings during the home tour: 1. The resident rooms #1, #2, and #3 were not provided with door knobs and door latches to secure the doors when they closed. The lack of latches and doorknobs on the resident doors did not allow for a positive latching of the doors or proper use of the doors during a fire or emergency. 2. The front entrance door had a deadbolt lock that required a key on the inside to exit the home. Survey staff explained to the LALD-A that the front door is the primary mean of escape in the home and must not be locked against egress. In addition, any lock in the means of egress that require prior and/or special knowledge will cause delay and impede exiting from the home during a fire or similar emergency and is not allowed. The LALD-A verified the finding and stated that she will get the lock changed out as soon as possible by Friday and she intended on using the storm door (with a lock) until the hardware on the entrance was repaired. 3. The door separating the upper level from the lower-level floors had a door hasp hardware that can be locked in the means of egress if a padlock was used. This would restrict exiting from the lower level floor. Survey staff explained to the LALD-A that although there was no padlock on or	0 800		

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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
0 800	Continued From page 12 near the door hasp, the hardware must be removed from any accidental locking of the door inhibiting egress from the lower level. The LALD-A stated that she was not aware of the hardware being there. 4. The screen on the sliding door to the deck was installed backward as there was no handle to use to open the screen from the inside. 5. No carbon monoxide detectors were observed during the tour of the home. 6. Furnace filter was heavily layered with dust. On June 28, 2022, at approximately 3:10 p.m. the LALD-A confirmed the findings. No further information was provided. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35315	A. BUILDING: _____ B. WING _____	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS CARE LLP	1065 DENNIS STREET SOUTH MAPLEWOOD, MN 55119

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0 810	Continued From page 13 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, required employee training, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, 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 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:	0 810		

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0 810	Continued From page 14 On June 28, 2022, at approximately 2:15 p.m. survey staff received and reviewed the facility's fire safety and evacuation documentation, the evacuation drill, and the training documentation from the licensed assisted living director (LALD)-A. FIRE SAFETY AND EVACUATION PLAN 1) The plan documentation lacked fire protection procedures for residents. 2) The plan documentation lacked a building evacuation lower level floor plan to show the location and number of resident sleeping rooms. 3) The home's fire policy (undated), 9.06, lacked site-specific fire protection procedures for employees. The documentation incorrectly stated that the home was provided with a fire sprinkler system by indicating that sprinklers will be activated when fire alarms were pulled. In addition, the procedures also referred to fire doors which the home did not have. 4) The plan documentation lacked fire protection procedures necessary for addressing resident movement, evacuation, and relocation including unique resident-specific situations during an evacuation. Unique situations during an evacuation may be residents who have mobility limitations, are non-ambulatory, bedridden, have a cognitive impairment, or any residents needing assistance during an evacuation and must be addressed in the fire safety and evacuation plan documentation. During the tour, survey staff observed a bed-bound resident that may need additional assistance during a fire and evacuation. DRILLS The review of the facility's documented drill record indicated licensee failed to show	0 810		

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0 810	Continued From page 15 compliance with the minimum number of required employee fire and evacuation drills performed to date for a minimum of two drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year: - The evacuation drill records showed drills performed did not cover all shifts and exceeded the minimum two-month frequency for drills performed on March 11, 2022, and June 10, 2022. Recorded drills provided and reviewed were, on January 5, 2022 (8:00 a.m.), February 10, 2022 (5:00 p.m.), March 11, 2022 (6:00 p.m.), and June 10, 2022 (6:00 p.m.). - No drills records were provided for the year 2021. TRAINING of FIRE SAFETY and EVACUATION The policy documentation (undated), 9.07, included the content of employee training on the fire safety and evacuation plan upon hiring and at least twice per year thereafter, but the licensee lacked documented records of employee training to show employee training has been performed per their adopted policy on the fire safety and evacuation plan. On June 28, 2022, at approximately 3:10 p.m. the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and	01330		

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01330	Continued From page 16 demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and competency tested in all required topics for one of two employees (unlicensed personnel (ULP)-B) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on March 20, 2019 to provide direct care services to the licensee's residents.	01330		

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01330	Continued From page 17 ULP-B's employee training record lacked evidence ULP-B successfully completed practical skills evaluations as required for training in the following areas: -appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - reading and recording temperature, pulse, and respirations of the resident; On June 28, 2022, at approximately 12:30 p.m., RN-A confirmed employee records of ULP-B lacked evidence of completed competency evaluations as indicated above and stated she may have provided this training, but could not locate the documentation. The licensee's Competency Training Evaluations policy, dated June 2021, directed ULP would receive training on required topics, to include oral competency testing and skill demonstration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01330		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living	01460		

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01460	Continued From page 18 facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for two of two employees (licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-B) with records reviewed. 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: LALD-A and ULP-B both had the hire date of March 20, 2019. The records of LALD-A and ULP-B lacked documentation the following orientation topic was completed: -An overview of assisted living laws 144.G. On June 28, 2022, at 11:00 a.m., LALD-A confirmed LALD-A and ULP-B had not yet completed the above listed required orientation topic.	01460		

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01460	Continued From page 19 The licensee's Orientation of Staff and Supervisors and Content policy, dated June 2021, directed all staff must complete orientation to Assisted Living Facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.	01530		

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01530	Continued From page 20 Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the required hours of dementia care training for two of two employees (licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-B) with training records reviewed. 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: LALD-A and ULP-B both had start dates of March 20, 2019. Both records lacked documentation of the required eight hours of initial dementia care training within 120 and 160 working hours of the employment start date, respectively. On June 28, 2022, at 11:30 a.m. the LALD-A stated she was not aware eight hours of dementia training was required if the licensee did not provide dementia care. The licensee's Dementia Training policy, dated June 2021, directed supervisors of direct-care staff must have at least eight hours of initial dementia training within 120 working hours of the employment start date, and direct-care employees must have completed at least eight	01530		

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01530	Continued From page 21 hours of initial dementia training within 160 working hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 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	01620		

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01620	Continued From page 22	01620		

review, the licensee failed to ensure resident reassessment and monitoring did not exceed 90 days from the last date of the assessment for one of one resident (R1) with records reviewed.

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:

R1 was admitted to the facility on August 18, 2021, for care under the licensee's assisted living facility license.

R1's service plan dated August 31, 2021, indicated R1 received services to include medication management, activities of daily living assistance, and housekeeping.

R1's record lacked documentation of a resident assessment within 90 calendar days of the previous assessment, which was completed on November 16, 2021.

On June 28, 2022, at approximately 10:30 a.m., registered nurse (RN)-A confirmed the licensee did not complete R1's reassessment within 90 days of the previous assessment as required, and was not sure how it was missed.

The licensee's Assessment, Reviews, and Monitoring policy, dated June 2021, directed resident reassessment and monitoring be conducted no more than 90 calendar days from

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01620	Continued From page 23 the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *06/28/22*
Time: 12:38:31
Report: 7963221058

Food and Beverage Establishment Inspection Report

Location:
Hands Care Llp
1065 Dennis Street South
Maplewood, MN55119
Ramsey County, 62

Establishment Info:
ID #: 0038630
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123066157
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

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

NO EMPLOYEE ILLNESS LOG ON SITE. BLANK LOG AND FACT SHEET EMAILED TO ESTABLISHMENT.

Comply By: 06/28/22

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 SHELL EGGS STORED OVER PRODUCE. CORRECTED ON SITE.

Corrected on Site

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD MANAGER. MS. MACRAE IS IN PROCESS OF TAKING FOOD SAFETY CLASS. APPLICATION AND FACT SHEET EMAIL.

Comply By: 06/28/22

6-300 Physical Facility Numbers and Capacities

6-303.11B

MN Rule 4626.1470B Provide at least 20 foot candles (215 LUX) of light intensity at a distance of 30 inches from the floor for areas where food is provided for consumer self-service, including buffets and salad bars or where fresh produce or packaged foods are sold or offered for consumption, inside equipment including reach-in and under counter refrigerators, in utensil storage areas, warewashing areas, and in toilet rooms.

LIGHT WAS NOT OPERATIONAL IN REFRIGERATOR. REPAIR/REPLACE BULB.

Comply By: 06/28/22

Surface and Equipment Sanitizers

Chlorine: = 400PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

MET WITH GLORIA MACRAE. DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-COOKING TEMPERATURES
-PROPER SANITIZING OF UTENSILS AND DISHWARE
-RESTRICTIONS CONCERNING SERVING A SUSCEPTIBLE POPULATION

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE SURVEYOR ROBYN WOOLEY.
FINDINGS SHARED AT END OF INSPECTION.
WILL EMAIL ASSORTED FACT SHEETS TO OPERATOR.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE. ONLY ONE CLIENT IN RESIDENCE AT TIME OF INSPECTION.
FLOOR IS SHEET LINOLEUM, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERTOP IS SOLID SURFACE AND CEILING IS POPCORN TEXTURE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO
BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.
WHIRLPOOL BRAND DISHWASHER IS RESIDENTIAL BUT IS TAGGED AS MEETING NSF/ANSI STANDARD 184.

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 7963221058 of 06/28/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

Gloria Macrae
PIC

Signed:_____

Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963221058

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	3	Date	06/28/22
No. of Repeat RF/PHI Categories Out	0	Time In	12:38:31
Legal Authority MN Rules Chapter 4626		Time Out	

Hands Care Llp	Address: 1065 Dennis Street South	City/State: Maplewood, MN	Zip Code: 55119	Telephone: 6123066157

License/Permit #: 0038630	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	X
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		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	X	Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 06/28/22

Inspector (Signature)