DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

April 7, 2025

Licensee
Serenehands Home Health Care
5913 York Avenue North
Brooklyn Center, MN 55429

RE: License Number 416840
Health Facility Identification Number (HFID) 36280
Project Number(s) SL36280015

Dear Licensee:

On March 6, 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 30, 2024, and the follow-up survey completed on November 18, 2024. The 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 6, 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.

Also, at the time of this follow-up survey completed on March 6, 2025, we identified the following violation(s):

0830 - Local Laws Apply - 144g.45 Subd. 3

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY
Per 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	R 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HEART HEALTH SERVICES	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

(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#36280015-2 On March 4, 2025, to March 6, 2025, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 18, 2024. At the time of the survey, there were no residents; no residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were 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.	
{0 100} SS=C	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	{0 100}		

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{0 100}	Continued From page 1	{0 100}		

facility may operate in Minnesota unless it is licensed under this chapter.

(2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).

(b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.

(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).

(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.

(e) Upon approving an application for an assisted living facility license, the commissioner may:

(1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or

(2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.

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{0 100}	Continued From page 2 This MN Requirement is not met as evidenced by:	{0 100}	Not reviewed during this survey.	
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required 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.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in	{0 250}		

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{0 250}	Continued From page 3 any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by:	{0 250}	Not reviewed during this survey.	

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{0 250}	Continued From page 4	{0 250}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a	{0 480}		

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{0 480}	Continued From page 5 handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the	{0 485}		

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{0 485}	Continued From page 6 resident's contract. This MN Requirement is not met as evidenced by:	{0 485}	Not reviewed during this survey.	
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.	
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	{0 660}		

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{0 660}	Continued From page 7 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}		
			Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	{0 680}		

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{0 680}	Continued From page 8 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 720} SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by:	{0 720}	Not reviewed during this survey.	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate	{0 780}		

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{0 780}	Continued From page 9 sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{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 maintained in accordance with the State Fire Code; and	{0 790}		

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{0 790}	Continued From page 10 This MN Requirement is not met as evidenced by:	{0 790}	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) staff 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) Staff 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 staff 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.	{0 810}		

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{0 810}	Continued From page 11 This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
0 830 SS=E	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements when the licensee failed to obtain required permits for replacement of egress windows. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 830		

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0 830	Continued From page 12 On March 4, 2025, from 12:30 p.m. to 12:55 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. The surveyor confirmed that the windows in resident rooms 1 and 2 had been replaced and met the minimum opening requirement. On March 4, 2025, at 12:50 p.m., LALD/CNS-C stated a permit was obtained by the contractor for resident rooms 1 and 2's installed windows and would email the surveyor a copy of the permit. On March 4, 2025, at 2:51 p.m., surveyor sent LALD/CNS-C surveyor's contact information. On March 5, 2025, at 1:55 p.m., the surveyor emailed the licensee a second request for a copy of the resident rooms 1 and 2's window permit be emailed to the surveyor. On March 6, 2025, at 11:36 p.m., licensee emailed surveyor that indicated the contractor did not pull a permit for the windows that were replaced in resident rooms 1 and 2. On March 6, 2025, at 12:00 p.m., per phone conversation, LALD/CNS-C stated permit was not pulled by the contractor for the windows installed in resident rooms 1 and 2. Minnesota Administrative Rule 1300.0120 dated March 31, 2020, indicated an owner or authorized agent who intends to construct, enlarge, alter, repair, move, demolish, or change the occupancy of a building or structure, or to erect, install, enlarge, alter, repair, remove, convert, or replace any gas, mechanical, electrical, plumbing system, or other equipment, the installation of which is regulated by the code; or cause any such work to	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	R 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HEART HEALTH SERVICES	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 830	Continued From page 13 be done, shall first make application to the building official and obtain the required permit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
{0 900} SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the	{0 900}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	R 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 900}	Continued From page 14 facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}	Not reviewed during this survey.	
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	{0 910}	Not reviewed during this survey.	
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04,	{0 940}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 940}	Continued From page 15 subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	{0 940}	Not reviewed during this survey.	
{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	{0 970}		

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{0 970}	Continued From page 16 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.	
{01290} SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}	Not reviewed during this survey.	
{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	{01530}		

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PURE HEART HEALTH SERVICES	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

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{01530}	Continued From page 17 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. 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:	{01530}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	{01620}	Not reviewed during this survey.	

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PURE HEART HEALTH SERVICES	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

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{01620}	Continued From page 18 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:	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	{01640}	Not reviewed during this survey.	

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{01640}	Continued From page 19 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.	
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of 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.	
{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	{01820}		

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{01820}	Continued From page 20 managing for the resident. This MN Requirement is not met as evidenced by:	{01820}	Not reviewed during this survey.	
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.	
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security	{03090}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	R 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HEART HEALTH SERVICES	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

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{03090}	Continued From page 21 cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	{03090}	Not reviewed during this survey.	

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 10, 2024

Licensee
SereneHands Home Health Care
5913 York Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 416840
Health Facility Identification Number (HFID) 36280
Project Number(s) SL36280015

Dear Licensee:

On November 18, 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 30, 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 90-day conditional license due to expire on **March 10, 2025**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 30, 2024, found not corrected at the time of the November 18, 2024, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on November 18, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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 SereneHands Home Health Care, 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 SereneHands Home Health Care is in substantial compliance.

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

a. **Health Facility Construction Permit: SereneHands Home Health Care**, 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, SereneHands Home Health Care, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.**

b. **General Contractor:** SereneHands Home Health Care must provide the following to Tim Hanna, at 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:** SereneHands Home Health Care will replace at least one window in unoccupied resident bedroom 1 and 2, 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 SereneHands Home Health Care 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 SereneHands Home Health Care is in substantial compliance on the follow up survey, MDH will remove the conditions from SereneHands Home Health Care's assisted living facility license, and SereneHands Home Health Care will correct any outstanding violations identified during the survey. If SereneHands Home Health Care 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/HRD-Appeals-Form.

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	R 11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENEHANDS HOME HEALTH CARE	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

(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: SL36280015-1 On November 18, 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 30, 2024. At the time of the survey, there were no residents; none 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.	
{0 100} SS=C	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	{0 100}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	R 11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENEHANDS HOME HEALTH CARE	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
{0 100}	Continued From page 1	{0 100}		

facility may operate in Minnesota unless it is licensed under this chapter.

(2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).

(b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.

(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).

(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.

(e) Upon approving an application for an assisted living facility license, the commissioner may:

(1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or

(2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.

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{0 100}	Continued From page 2 This MN Requirement is not met as evidenced by:	{0 100}	Not reviewed during this survey.	
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required 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.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a	{0 250}		

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{0 250}	Continued From page 3 material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by:	{0 250}	Not reviewed during this survey.	

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{0 250}	Continued From page 4	{0 250}		
{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.	
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) 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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by:	{0 485}		

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{0 485}	Continued From page 5	{0 485}	Not reviewed during this survey.	
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.	
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	{0 660}		

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{0 660}	Continued From page 6 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	{0 680}	Not reviewed during this survey.	

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{0 680}	Continued From page 7 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 720} SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by:	{0 720}	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	{0 780}		

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{0 780}	Continued From page 8 separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{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 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	{0 790}		

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{0 790}	Continued From page 9 by:	{0 790}	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 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.	{0 810}		

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{0 810}	Continued From page 10 This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{0 820} SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited	{0 820}		

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{0 820}	Continued From page 11 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On November 18, 2024, at 11:35 a.m., the surveyor called licensee at the phone number on record, there was no answer by licensee and no voicemail available to leave a message. On November 18, 2024, at 11:55 a.m., the surveyor arrived at the entrance of the licensee's facility to initiate a revisit to follow-up on orders issued pursuant to a survey completed on August 30, 2024. The surveyor observed no vehicles parked in the driveway. The surveyor knocked on the door and rang the doorbell located at the front and side doors but received no answer. The surveyor looked inside the side door window and no licensee staff or residents was observed. On November 18, 2024, at 4:29 p.m., per phone conversation, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had no residents at the facility since December 2023 and had not replaced the windows due to financial constraints. LALD/CNS-C also stated the current window measurements would be the same as the previous survey. The surveyor explained to LALD/CNS-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD/CNS-C verbally confirmed the findings. Unoccupied Resident Sleeping Room measurements from previous survey on August	{0 820}		

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{0 820}	Continued From page 12 30, 2024: Bedroom 1: window measured 32 inches clear width, 13 inches clear height, and 416 square inches total open area. Bedroom 2: window measured 32 inches clear width, 13 inches clear height, and 416 square inches total open area. The windows in bedrooms 1 and 2 did not meet the minimum requirements for clear height and total openable area. On November 18, 2024, at 5:29 a.m., LALD/CNS-C emailed the surveyor and indicated the licensee was unable to complete the window repairs due to financial constraints. 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. No further information was provided.	{0 820}		
{0 900} SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	{0 900}		

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{0 900}	Continued From page 13 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}		
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and	{0 910}	Not reviewed during this survey.	

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{0 910}	Continued From page 14 (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	{0 910}	Not reviewed during this survey.	
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;	{0 940}		

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{0 940}	Continued From page 15 (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	{0 940}	Not reviewed during this survey.	
{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.	
{01290} SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	{01290}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	R 11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENEHANDS HOME HEALTH CARE	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
{01290}	Continued From page 16 (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}	Not reviewed during this survey.	
{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. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	{01530}		

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{01530}	Continued From page 17 This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.	
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.	
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	{01640}		

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{01640}	Continued From page 18 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.	
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	{01760}		

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{01760}	Continued From page 19 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.	
{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.	
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	{01910}		

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{01910}	Continued From page 20 (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.	
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	{03090}	Not reviewed during this survey.	

Electronically Delivered

October 8, 2024

Licensee
Serenehands Home Health Care
5913 York Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36280015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 30, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

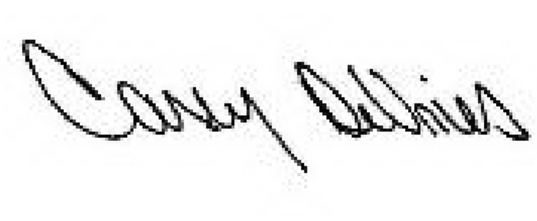
INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Serenehands Home Health Care. Please contact Casey DeVries at 651-201-5917 on or before Friday, October 11, 2024, to schedule the conference call.

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: SL36280015-0 On August 28, 2024, through August 30, 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 no residents under the provider's Assisted Living Facility license.	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.	
0 100 SS=C	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100		

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and record review although the licensee had no residents at the time of the survey, the licensee previously operated as an assisted living facility despite housing a mixed occupancy of assisted living residents and comprehensive home care residents within one structure. 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 the potential to affect a large portion or all the residents). The findings include: R1 R1 admitted to the licensee on September 8, 2021, and discharged on December 2, 2024. R1's diagnoses included depressive disorder, generalized anxiety disorder, traumatic brain injury, and polysubstance abuse. R1's Service Plan signed on December 21, 2020, indicated R1 received assistance with medication administration, showers, grooming, dressing, laundry, and meals. R1's billing statement dated October 12, 2021, included a billing code T2031 indicating R1 received assisted living services.	0 100		

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0 100	Continued From page 3 R2 R2 admitted to the licensee on November 2, 2022, and discharged on July 7, 2023. R2's diagnoses included major depressive disorder, generalized anxiety disorder, and intellectual disability. R2's unsigned Service Plan (Wavier) -Addendum to Contract with effective date of August 15, 2024, indicated R2 had received assistance with activities, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, and pain management. Although requested, the surveyor did not receive R2's billing statement prior to the completion of survey. R3 R3 admitted to the licensee on February 1, 2022, and discharged on July 7, 2023. R3's diagnoses included chronic respiratory failure with hypoxia, chronic pain, quadriplegia (paralysis that affects all limbs and body from the neck down), diabetes, neurogenic bladder, depression. R3's Service Plan (Waiver) - Addendum to Contract with effective date of August 29, 2024, indicated R3 received assistance with activities, bathing, catheter care, colostomy care, dressing, drinking, grooming, incontinence care, laundry, meals, medication administration, positioning, blood glucose, urinary output monitoring, tracheotomy care including respiratory equipment, site care, and changes, transfer assistance, and wound care.	0 100		

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0 100	Continued From page 4 R3's billing information dated April 24, 2023, included a code T1002 indicating R3 received comprehensive home care services. On August 28, 2024, at 12:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee used private duty nurses (PDN) for one of the residents who resided in the assisted living facility. LALD/CNS-C stated for the one resident who had PDN they used their comprehensive license to bill for the care being provided. On August 28, 2024, at 1:20 p.m., LALD/CNS-C stated R1 and R2 were charged under assisted living and R3 was charged under comprehensive home care due to having tracheostomy care, wound care, ostomy care, and suprapubic catheter care. On August 28, 2024, at 1:44 p.m., LALD/CNS-C stated when admitted to the facility, R3 received 24 hours PDN and 12 hours of personal care attendant (PCA) assistance. LALD/CNS-C stated R3's services then decreased to 18.5 hours of PDN and eight or four hours of assisted living staff. On August 28, 2024, at 1:44 p.m., LALD/CNS-C stated they were unable to find billing information for R2 and they would have to look for a paper copy at their office. On August 29, 2024, at 3:24 p.m., LALD/CNS-C stated they were aware they could not have a mixed occupancy facility however, R3 lived in the facility prior to the change of license. LALD/CNS-C stated the licensee was "grandfathered" to keep R3 after the license	0 100		

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0 100	Continued From page 5 changed to assisted living because R3 lived there prior to the license change. The surveyor asked if they had paperwork to show they were able to have R3 in the facility after the license converted to an assisted living facility. LALD/CNS-C stated they were unable to find it. LALD/CNS-C stated they did not take any more residents who required comprehensive home care services to the assisted living after the license converted however, they were not going to discharge a resident who already was living at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required 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 observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record 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	0 110		

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0 110	Continued From page 6 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). These findings include: On August 28, 2024, at 10:03 a.m. the surveyor observed the Board of Executives for Long-Term Services and Supports (BELTSS) website which indicated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C held a current assisted living director license, however, was not listed as the director of record for the licensee. LALD/CNS-C stated they were familiar with being listed as the director of record however, they did not know why they were not listed for the licensee's address. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;	0 250		

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	36280	A. BUILDING: _____ B. WING _____	08/30/2024

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0 250	Continued From page 7 (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the	0 250		

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0 250	Continued From page 8 assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 28, 2024, at 10:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was	0 250		

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0 250	Continued From page 9 placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the	0 250		

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0 250	Continued From page 10 appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and	0 250		

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0 250	Continued From page 11 Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page four was electronically signed by LALD/CNS-C on February 20, 2024. The licensee had an assisted living license issued on June 1, 2024, with an expiration date of May 31, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - medication and treatment management. On August 19, 2024, at 4:15 p.m., LALD/CNS-C confirmed the licensee provided assisted living services but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0100, 0110, 0480, 0485, 0650, 0660,	0 250		

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0 250	Continued From page 12 0680, 0720, 0780, 0790, 0810, 0820, 0900, 0910, 0940, 0970, 1290, 1530, 1620, 1640, 1760, 1820, 1910, 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
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. 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:	0 480		

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0 480	Continued From page 13 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 28, 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		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) 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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; 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 require any resident to include and pay for meals as a part of their assisted living	0 485		

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0 485	Continued From page 14 package fee for two of two residents (R1, R2). 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: R1 R1 admitted to the licensee on September 8, 2021, for assisted living services and discharged from the licensee on December 12, 2023. R1's Residency Agreement signed December 17, 2020, included a section titled Attachment A to Residency Agreement and read, "The following facilities and services are included in the rent: - All utilities, including gas and electric - Private Room, furnished with bed, bedside table/lamp stand - Three meals per day plus snacks". The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee. R2 R2 admitted to the licensee on November 2, 2022, for assisted living services and discharged from the licensee on July 7, 2023. R2's Residency Agreement signed December 19, 2022, included a section titled Attachment A to Residency Agreement and read, "The following facilities and services are included in the rent: - All utilities, including gas and electric	0 485		

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0 485	Continued From page 15 - Private Room, furnished with bed, bedside table/lamp stand - Three meals per day plus snacks". The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee. On August 29, 2024, at 3:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had one base fee because residents were on waivered services and were not private pay. LALD/CNS-C stated the licensee was required to provide meals to residents with waivered services. LALD/CNS-C stated, "it is not a one fit all situation" and due to residents being on waivered services that is why it was included in the base fee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 16 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on August 16, 2021, to provide direct care services to residents. R1's Med Admin Summary- Month dated November 2023 indicated ULP-B administered medication to R1 on Tuesday November 28, 2023. ULP-B's employee record lacked the following: - documentation of annual performance reviews that identified areas of improvement needed and	0 650		

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0 650	Continued From page 17 training needs; - orientation which included overview of assisted living statues, assisted living bill of rights, review of types of assisted living services the employee would provide and providers scope of license, and principles of person-centered planning/service delivery; -annual training; -training which included falls, awareness of confidentiality and privacy, and understanding boundaries between staff and residents; -competency evaluations which included the 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, dressing and assisting with toileting, vital signs, safe transfer and techniques and ambulation, range of motion and positioning, and medication administration; and - 30-day supervision of delegated tasks. On August 29, 2024, at 12:03 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated all ULP attended a three-day orientation upon hire. LALD/CNS-C stated ULP had been oriented, trained, and competency evaluated for the comprehensive license and the assisted living license requirements. On August 29, 2024, at 12:22 p.m., LALD/CNS-C stated they completed all the required training but did not document when the training was completed. LALD/CNS-C stated they found out they were not documenting correctly on what they were providing to employees during a previous investigation survey. On August 29, 2024, at 12:33 p.m., LALD/CNS-C	0 650		

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0 650	Continued From page 18 stated they completed performance reviews with each employee. LALD/CNS-C stated they used to complete the reviews on paper format however transitioned to electronic in 2022 and had misplaced the paper copies. CNS-C was unable to locate an electronic performance review. On August 29, 2024, at 12:56 p.m., ULP-B stated they received a performance evaluation from LALD/CNS-C. ULP-B stated they received all training, competency evaluations, and orientation listed above by LALD/CNS-C. In addition, ULP-B stated LALD/CNS-C completed a 30-day supervision with them. The licensee's undated 3.43 Orientation policy indicated upon hire and prior to performing any functions of the employees' position, each new employee would be orientated in accordance with state and federal regulation, as well as company policy and procedure. Although requested, the surveyor did not receive a policy related to training, competency evaluations, delegation of tasks by registered nurses, supervision of unlicensed personnel performing delegated tasks prior to the completion of the survey. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 19 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a facility TB risk assessment. In addition, the licensee failed to complete a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of one employee (ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: FACILITY RISK ASSESSMENT	0 660		

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0 660	Continued From page 20 Although requested multiple times, the surveyor did not receive the licensee's TB facility risk assessment prior to the completion of the survey. ULP-B ULP-B was hired on August 16, 2021, to provide direct care services to residents. ULP-B's employee record included a document titled Baseline TB Screening Tool for Health Care Workers (HCWs) dated August 18, 2021. The form included the health history screen and an area to record a TST or TB blood test. The TST and /or TB blood test was not completed. In addition, ULP-B's record contained an Immunization Summary dated October 20, 2021, which indicated ULP-B received a TST on August 4, 2010, and November 24, 2011. The Immunization Summary lacked the TST results and was not completed within 90 days of hire to the licensee. On August 29, 2024, at 12:35 p.m., LALD/CNS-C stated the licensee completed a health history screen for TB on each employee and requested the employee bring in a chest Xray or Mantoux result. LALD/CNS-C stated if they did not have a chest Xray or Mantoux they would send the employee to their medical provider to receive one. LALD/CNS-C stated they believed they saw the document that showed the result of the TSTs listed above however; they were unable to locate it. The CDC's document titled Baseline TB Screening and Testing dated December 19, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment;	0 660		

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0 660	Continued From page 21 - TB symptom evaluation; and - a TB test which could include TB blood test or TB skin test. Although requested, the surveyor did not receive a policy from the licensee related to TB prior to the completion of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	0 680		

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0 680	Continued From page 22 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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 28, 2024, at 11:11 a.m., the surveyor observed a four-page undated EPP on the wall in the living room. There were no exit diagrams posted on each floor of the two-story home (facility). The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - exit diagrams posted on each floor of the facility; - annual review; - hazard vulnerability risk assessment; - develop strategies for addressing facility and community-based risks including staffing surges and shortages and evacuation plans; - quarterly review of missing resident policy;	0 680		

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0 680	Continued From page 23 - emergency plan (EP) patient population; - process for EP collaboration; - subsistence needs for staff and residents; - procedures for tracking staff and residents; - policies and procedures for evacuation including transportation, primary communication means with external sources of assistance; - policy and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - development of communication plan; - names and contact information to include resident's physicians; - emergency officials contact information to include regional and local EP staff, and state licensing and certification agency; - primary means for communication; - methods for sharing information; - sharing information on occupancy/needs; - long term care family notifications; and - emergency prep testing requirements. On August 8, 2024, at 11:56 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee held an in service related to fire drills but did not conduct drills because the licensee had a small facility. LALD/CNS-C stated the EPP was posted on the wall. The licensee's undated 4:01 Disaster Planning and Emergency Preparedness Plan policy indicated the licensee would have in place a written emergency and disaster plan, signage, directions, training, and drills to facilitate the management of tenant's care [residents] and services in response to a natural disaster or other emergencies.	0 680		

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0 680	Continued From page 24 No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that facility assessments, facility policies, personnel records, and resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. 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: FACILITY RISK ASSESSMENT	0 720		

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0 720	Continued From page 25 On August 28, 2024, via email, at 10:51 a.m., and 1:44 p.m., the surveyor requested the licensee's tuberculosis (TB) facility risk assessment. On August 29, 2024, at 2:04 p.m., 2:59 p.m., and 4:15 p.m., the surveyor requested the licensee's TB facility risk assessment. On August 29, 2024, at 2:59 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee's TB facility risk assessment was located at their Blaine office. August 30, 2024, via email, at 9:34 a.m., the surveyor requested the licensee's TB facility risk assessment. Although requested, the surveyor did not receive the licensee's TB facility risk assessment prior to the completion of the survey. POLICIES In addition to verbal requests, the surveyor requested the licensee's policies and procedures on August 28, 2024, at 10:51 a.m., and 1:44 p.m., on August 29, 2023, at 7:23 a.m., and 2:11 p.m., and on August 20, 2024, at 6:46 a.m., and 9:24 a.m. On August 29, 2024, at 4:15 p.m., LALD/CNS-C stated the policies were located in their off-site office. The licensee provided the surveyor with six of the policies requested which included background checks, orientation, dementia training, disaster planning, assessment, and service plans. The surveyor did not receive the following required policies prior to the completion of the survey: - requirements in section 626.557, reporting of maltreatment of vulnerable adults;	0 720		

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0 720	Continued From page 26 - training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial evaluations of residents' needs and the providers' ability to provide those services; - orientation to and implementation of the assisted living bill of rights; - infection control; - reminders for medications, treatments, or exercises, if provided; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and practices Prevention standards; - ensuring that nurses and licensed health professionals have current and valid licenses to practice; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. PERSONNEL RECORDS On August 28, 2024, at 2:25 p.m., the surveyor requested ULP-A, ULP-B, and ULP-D's employee files. LALD/CNS-C stated the files were located at the other office location. The surveyor requested they be brought in when the survey resumed the next day. On August 29, 2024, at 11:42 a.m., LALD/CNS-C stated they were unable to locate ULP-A and	0 720		

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0 720	Continued From page 27 ULP-D's employee record. LALD/CNS-C stated they attempted to contact the program director to locate the employee records but were unable to get ahold of the program director. LALD/CNS-C was able to provide one of the three employee records requested (ULP-B). BILLING The surveyor requested R2's billing statement on August 28, 2024, at 1:20 p.m., and 2:17 p.m., on August 29, 2024, at 9:20 a.m., 1:50 p.m., 3:02 p.m., and 4:15 p.m., on August 20, 2024, at 6:47 a.m. On August 28, 2024, at 1:44 p.m., LALD/CNS-C stated they were unable to find billing information for R2 and they would have to look for a paper copy at the Blaine office. Although requested the surveyor did not receive R2's billing statement prior to the completion of survey. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720		
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;	0 780		

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0 780	Continued From page 28 (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 that the actuation of one alarm causes all alarms in the dwelling unit to actuate and failed to keep the facility in compliance with the Minnesota Fire Code. These deficient conditions had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 780		

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0 780	Continued From page 29 On facility tour with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C on August 28, 2024, between 11:15 a.m. and 12:15 p.m. the following deficient conditions were observed: EXTENSION CORD: The surveyor observed an extension cord tacked to the wall and going through the ceiling in the room outside the kitchen. The surveyor explained to the LALD/CNS-C extension cords cannot be used for permanent use and go through walls/ceilings. RESIDENT ROOM 4: The surveyor observed that the basement egress window was blocked from being fully openable by the cover. The surveyor explained to the LALD/CNS-C that the egress window shall be always fully openable. SMOKE ALARMS: The surveyor observed that the smoke alarms in the facility were not interconnected. The surveyor explained to the LALD/CNS-C that all the smoke alarms in the facility shall be interconnected. These deficient conditions were visually verified by the LALD/CNS-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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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 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition 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) 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 facility tour with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C on August 28, 2024, between 11:15 a.m. and 12:15 p.m. the following deficient condition was observed:	0 790		

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0 790	Continued From page 31 The portable fire extinguishers throughout the facility needed their annual inspection. The surveyor explained to the LALD/CNS-C that all fire extinguishers shall have the annual inspection completed to meet the state fire code requirements. The deficient condition was visually verified by the LALD/CNS-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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	0 810		

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0 810	Continued From page 32 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on August 28, 2024, at approximately 12:00 p.m. with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility.	0 810		

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0 810	Continued From page 33 FIRE SAFETY AND EVACUATION PLAN: During record review the plan was noted as generic, was behind glass hanging on the wall and did not meet the state statue. FIRE/EVACUATION DRILLS: During record review the LALD/CNS-C stated the fire/evacuation drills were not being completed. TRAINING: During record review the LALD/CNS-C stated the training had not been completed and documented for the employees and residents. The surveyor explained to LALD/CNS-C the employees shall be trained specifically on their fire safety and emergency plan at new hire and twice a year thereafter. Also, the residents shall be offered the training once a year. Both shall be documented. The fire safety and evacuation plan shall be updated and continue to be always updated annually and available within the facility. The fire drills shall be completed twice per year on each shift, at least one every other month and this shall be documented with date, time and signatures of who participated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under	0 820		

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0 820	Continued From page 34 chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On facility tour with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C on August 28, 2024, between 11:15 a.m. and 12:15 p.m. the following deficient condition was observed: Resident rooms 1 and 2 windows measured	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	08/30/2024

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0 820	Continued From page 35 32"X13"X46". Neither of these rooms were occupied. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. Surveyor explained to LALD/CNS-C that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. She stated they would not have a resident sleep in these rooms until a code compliant escape window is installed. These deficient conditions were visually verified by LALD/CNS-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to	0 900		

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0 900	Continued From page 36 the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content post implementation of 144G Statutes for one of one discharged resident (R1). 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 the potential to affect a large portion or all the residents). The findings include: The licensee converted to an Assisted Living Facility license on August 1, 2021.	0 900		

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0 900	Continued From page 37 R1 admitted to the licensee on September 8, 2021, for assisted living services and discharged from the licensee on December 12, 2023. R1's Residency Agreement was signed December 17, 2020. R1 did not receive the required post 144G Statute contract to be provided to residents prior to providing housing or assisted living services. On August 29, 2024, at 10:11 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they billed for assisted living however, they continued using the housing with services contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910		

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0 910	Continued From page 38 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written contract with the required content for any potential future residents of the assisted living facility. 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 the potential to affect a large portion or all the residents). The findings include: On August 29, 2024, at 10:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided the surveyor the licensee's blank contract titled Residency Agreement and stated it was to be used for all residents who would admit to the assisted living facility and was used for discharged residents. The licensee's Assisted Living Contract for Housing and Services lacked the following required content: - in a conspicuous place and manner on the contract the health facility identification number (HFID#) of the facility. On August 29, 2024, at 10:11 a.m., LALD/CNS-C verified the contract lacked the HFID# and stated they believed the HFID# was located on an addendum of the contract. The surveyor observed the addendum which lacked the HFID#. On August 29, 2024, at 3:40 p.m., LALD/CNS-C stated they believed the contract contained all	0 910		

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0 910	Continued From page 39 required content because it was reviewed by a lawyer prior to the licensee issuing the contract to any residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for	0 940		

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0 940	Continued From page 40 people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written contract with the required content for any potential future residents of the assisted living facility. 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 29, 2024, at 10:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided the surveyor the licensee's blank contract titled Residency Agreement and stated it was to be used for all residents who would admit to the assisted living facility and was used for discharged residents. The contract lacked the licensee's information on the following content: - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether the facility requires a resident to pay	0 940		

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0 940	Continued From page 41 privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On August 29, 2024, at 3:40 p.m., LALD/CNS-C stated they believed the contract contained all required content because it was reviewed by a lawyer prior to the licensee issuing the contract to any residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
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	0 970		

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0 970	Continued From page 42 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 future residents of the assisted living facility. 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 29, 2024, at 10:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided the surveyor the licensee's blank contract titled Residency Agreement and stated it was to be used for all residents who would admit to the assisted living facility and was used for discharged residents. The licensee's contract included the following sections titled Be Responsible for the Costs of and No Liability of Owner which contained language waving the licensee's liability for health, safety, or personal property of a resident and read the following: - "Any loss, property damage, repair, service (including plumbing) or injury to any person, including but not limited to owner' employees, caused by the acts of Client, Client's agents, family members or visitors, regardless of it being intentional or unintentional and whether or not under client's control or direction";	0 970		

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0 970	Continued From page 43 - "Client assumes all risk for harm to or loss of any of client's personal property."; and - "Owner, its employees, and its agents are not liable to client or to any other person for any loss or inconvenience of any kind, including personal injuries sustained by client or any other person, or any loss or damage to property, which is not a direct result of intentional or negligent acts in violation of applicable standards of care." On August 29, 2024, at 3:40 p.m., LALD/CNS-C stated they believed the contract contained all required content because it was reviewed by a lawyer prior to the licensee issuing the contract to any residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 44 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the licensee's current health facility identification number (HFID#) for two of four employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B was hired on August 16, 2021, to provide direct care services to residents. R1's Med Admin Summary- Month dated November 2023 indicated ULP-B administered medication to R1 on Tuesday November 28, 2023. ULP-D ULP-D was hired on February 10, 2023, to provide direct care services to residents. R1's Med Admin Summary- Month dated November 2023 indicated ULP-D administered medication to R1 on Tuesday November 28,	01290		

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01290	Continued From page 45 2023. On August 29, 2024, at 3:05 p.m., the surveyor observed the licensee's Minnesota Department of Human Services (DHS) NETStudy 2.0 (a web-based system used to submit background study requests) roster for HFID# 36280 and observed only three employees listed on the NETStudy 2.0 roster. The surveyor requested the licensee's corporate umbrella NETStudy 2.0 roster and observed the following: - ULP-B affiliated to HFID# 99192; and - ULP-D affiliated to HFID# 34523. On August 29, 2024, at 3:44 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they ran background studies under their company's comprehensive license and believed it was fine because they were affiliated with the company's comprehensive license. LALD/CNS-C stated there were issues affiliating employees to the correct HFID# due to having two DHS email addresses. LALD/CNS-C stated they previously contacted DHS to correct the issue and believed all employees were affiliated to the correct HFID# after they contacted DHS. The licensee's undated 3.38 Background Checks policy indicated once an approved background study was received, staff may act independently with tenants or clients [residents], assuming all other requirements had been met and copies of completed background studies shall be kept in individual personnel files. The policy lacked information related to an employee being affiliated to the licensee's HFID#. No further information provided.	01290		

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01290	Continued From page 46 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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. 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 direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working	01530		

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01530	Continued From page 47 hours of the employment start date for one of one direct care employee (unlicensed personnel (ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-B was hired on August 16, 2021, to provide direct care services to residents. ULP-B's employee record lacked any dementia care training. On August 29, 2024, at 12:25 p.m., LALD/CNS-C stated the licensee provided 40 minutes to an hour of dementia care training related to basic changes and behaviors to each new employee on day two of orientation. The surveyor reviewed the statute with LALD/CNS-C. LALD/CNS-C stated, "why would we take a whole day to train when we are not a dementia unit facility." LALD/CNS-C then stated they misspoke and said the licensee provided all of the required dementia care training on EduCare (a training software program). The surveyor requested EduCare transcripts. LALD/CNS-C stated they did not have EduCare transcripts because they did not use the program yet. The licensee's undated 3.65 Dementia Training policy did not meet the requirements of current licensure.	01530		

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01530	Continued From page 48 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments	01620		

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	36280	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENEHANDS HOME HEALTH CARE	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

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01620	Continued From page 49 that did not exceed 90 days for two of two residents (R1, 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 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 28, 2024, at approximately 10:01 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they completed an initial assessment, an assessment with in the first five days, every 90 days, and with change of condition. R1 R1 admitted to the licensee on September 8, 2021, and discharged on December 2, 2023. R1's diagnoses included depressive disorder, generalized anxiety disorder, traumatic brain injury, and polysubstance abuse. R1's Service Plan signed on December 21, 2020, indicated R1 received assistance with medication administration, showers, grooming, dressing, laundry, and meals. R1's record included an ongoing 90-day assessment completed May 30, 2022, July 6, 2022, and December 20, 2022, indicating 167 days passed between the July 6, 2022, assessment and December 20, 2022,	01620		

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01620	Continued From page 50 assessment. In addition, R1's record lacked further assessments indicating 347 days passed since R1 had their last assessment prior to discharge. R2 R2 admitted to the licensee on November 2, 2022, and discharged on July 7, 2023. R2's diagnoses included major depressive disorder, generalized anxiety disorder, and intellectual disability. R2's unsigned Service Plan (Wavier) -Addendum to Contract with effective date of August 15, 2024 (date printed during the survey), indicated R2 received assistance with activities, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, and pain. R2's record included an ongoing assessment dated December 20, 2022. R2's record lacked further assessments. On August 29, 2024, at 10:27 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee transitioned to electronic format in RTasks (a software documenting program) for completing assessments in 2022. LALD/CNS-C stated they were unable to locate the paper assessments for R2. LALD/CNS-C stated ongoing assessments were completed for R1 and R2 however, due to the transition from paper to electronic they had issues reflecting the date the assessments were completed on in RTasks. LALD/CNS-C stated Rtasks would reflect multiple assessments all completed on the same day however, each one of those assessments were a different 90-day	01620		

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01620	Continued From page 51 assessments. LALD/CNS-C stated they attempted to contact RTasks to correct the dates the assessments were completed however, RTasks was unable to change the dates the assessments. The surveyor inquired if they documented in the progress notes when they conducted the assessments. LALD/CNS-C stated they did however, they would have to look for them. The surveyor did not receive any progress notes related to when assessments were completed prior to the completion of the survey. The licensee's undated 4.03 Assessment Schedules policy did not meet the requirements of current licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all	01640		

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01640	Continued From page 52 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of three 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: R2 admitted to the licensee on November 2, 2022, for assisted living services and discharged from the licensee on July 7, 2023. R2's diagnoses included major depression, generalized anxiety disorder, and intellectual disability. R2's Residency Agreement signed December 19, 2022.	01640		

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01640	Continued From page 53 R2's unsigned Service Plan (Wavier) -Addendum to Contract with effective date of August 15, 2024 (date printed during the survey), indicated R2 received assistance with activities, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, and pain management. R2's updated service plan was printed after R2 discharged from the facility lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. On August 28, 2024, at approximately 10:01 a.m., during entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated service plans were created based on the nursing assessment. LALD/CNS-C stated the licensee received input from the resident, resident's doctor, case manager, and resident's family members. LALD/CNS-C stated the service plan was signed when created and with each revision to the services. On August 29, 2024, at 2:14 p.m., LALD/CNS-C stated they looked for R2's service plan again however, they were unable to locate the document. LALD/CNS-C stated they were there and signed it with R2's mother. The licensee's undated 4.09 Service Plan policy indicated all services provided to the clients [residents] of the licensee would be delivered after and assessment was completed by a registered nurse (RN) and a up-to-date service plan was signed by the RN and the client [resident] or the client's [resident's] representative.	01640		

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01640	Continued From page 54 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of 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 interview and record review, the licensee failed to document the reason why medication administration was not completed as prescribed for two of two residents (R1, 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 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).	01760		

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01760	Continued From page 55 The findings include: R1 R1 admitted to the licensee on September 8, 2021, and discharged on December 2, 2024. R1's diagnoses included depressive disorder, generalized anxiety disorder, traumatic brain injury, and polysubstance abuse. R1's Service Plan signed on December 21, 2020, indicated R1 received assistance with medication administration, showers, grooming, dressing, laundry, and meals. R1's RTasks (a documenting software program) census indicated R1 was active at the assisted living from September 8, 2021, to December 6, 2023. R1's Med Admin Summary - Month dated November 2023, included Carbamide 6.5 percent (%) twice a day, aripiprazole 10 milligrams (mg) daily, atorvastatin 40 mg daily, fluoxetine 40 mg, fluticasone 50 microgram (mcg) nasal spray one spray daily, gabapentin 100 mg three times a day, lisinopril 5 mg daily, metoprolol succinate extended release (ER) 50 mg daily, Xarelto 20 mg daily at dinner, and divalproex sodium 1500 mg daily at bedtime. The medications listed above were not documented in the medication administration record (MAR) for the morning doses on Friday November 3, 2023, the entire day on Wednesday November 29, 2023, and the morning doses Thursday November 30, 2023. R2 R2 admitted to the licensee on November 2, 2022, and discharged on July 7, 2023.	01760		

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01760	Continued From page 56 R2's diagnoses included major depressive disorder, generalized anxiety disorder, and intellectual disability. R2's unsigned Service Plan (Wavier) -Addendum to Contract with effective date of August 15, 2024, indicated R2 had received assistance with activities, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, and pain management. R2's RTasks census indicated the following for R2: - active in the facility from October 19, 2022, to November 2, 2022; - reserved from November 2, 2022, to November 14, 2022; - active in the facility from November 14, 2024, to February 24, 2023; and - hold for hospitalization from February 24, 2023, to July 7, 2023. R2's Med Admin Summary - Month dated January 2023 included buspirone 10 mg three times per day, fluoxetine 30 mg daily, fluticasone 50 mcg nasal spray daily, gabapentin 300 mg three times per day, lorazepam 0.5 mg twice per day, metformin 50 mg twice per day, aripiprazole 10 mg at bedtime, and benzoyl peroxide 0.5 % at bedtime. The medications had the following missed documentations on the MAR: - fluoxetine 10mg, fluticasone 50 mcg missed documentation on January 1, 2, 6, 7, 10, and 16 of 2023; - lorazepam 0.5 mg missed documentation on January 12, 15, 16, 21, 22, and 23 of 2023; - buspirone 10 mg, benzoyl peroxide 5 %, and gabapentin 300 mg missed documentation on January 1, 2, 3, 6, 7, 10, 12, 16, 22, 23, and 24 of	01760		

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01760	Continued From page 57 2023; - aripiprazole 10 mg missed documentation on January 12, 16, 21, 22, 23, and 24 of 2023; and - metformin missed documentation on January 1, 2, 3, 5, 6, 7, 8, 9, 10, 12, 16, 21, 22, 23, and 24 of 2023. On August 29, 2024, at 11:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R1's documentation may have been missed due to resident being in the hospital. In addition, LALD/CNS-C stated they were unable to provide R1's December medication administration record (MAR). On August 29, 2024, at 1:29 p.m., LALD/CNS-C stated staff were trained to document on the MAR the reason medications were not provided. The surveyor requested a MAR closer to the discharged date for R2. LALD/CNS-C stated they did not have another MAR because R2 was hospitalized from February 2023 until they discharged from the facility. LALD/CNS-C stated they believed the missed documentation on medications were due to resident being on a leave of absence (LOA) with their mother. Although a medication policy was requested, the surveyor did not receive a policy from the licensee prior to the completion of the survey. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	01820		

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01820	Continued From page 58 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 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: R2 admitted to the licensee on November 2, 2022, and discharged on July 7, 2023. R2's diagnoses included major depressive disorder, generalized anxiety disorder, and intellectual disability. R2's unsigned Service Plan (Wavier) -Addendum to Contract with effective date of August 15, 2024, indicated R2 had received assistance with activities, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, and pain management. R2's Med Admin Summary - Month dated January	01820		

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01820	Continued From page 59 2023 included buspirone 10 milligrams (mg) three times per day, fluoxetine 30 mg daily, fluticasone 50 micrograms (mcg) nasal spray daily, gabapentin 300 mg three times per day, lorazepam 0.5 mg twice per day, metformin 50 mg twice per day, aripiprazole 10 mg at bed time, benzoyl peroxide 0.5 percent (%) at bed time, acetaminophen 325mg to 650 mg as needed (PRN) every six hours, diclofenac 2 grams (g) topically four times a day PRN, hydroxyzine 25 mg to 50 mg every four hours PRN, lorazepam 0.5 mg twice a day PRN. On August 29, 2024, at 2:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided the surveyor a facsimile (fax) face sheet and a printout of R2's unsigned orders and stated the documents provided were faxed to the provider and had been returned with a signature. LALD/CNS-C stated they were unable to locate the signed provider orders. Although a medication management policy was requested, the surveyor did not receive a policy from the licensee prior to the completion of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	01910		

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01910	Continued From page 60 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, date of disposition, to whom the medications were given, and names of staff and other individuals involved in the disposition for two of two residents (R1, 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 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:	01910		

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01910	Continued From page 61 R1 R1 admitted to the licensee on September 8, 2021, and discharged on December 2, 2024. R1's diagnoses included depressive disorder, generalized anxiety disorder, traumatic brain injury, and polysubstance abuse. R1's Service Plan signed on December 21, 2020, indicated R1 received assistance with medication administration, showers, grooming, dressing, laundry, and meals. R1's Med Admin Summary - Month dated November 2023, included Carbamide 6.5 percent (%) twice a day, aripiprazole 10 milligrams (mg) daily, atorvastatin 40 mg daily, fluoxetine 40 mg, fluticasone 50 microgram (mcg) nasal spray one spray daily, gabapentin 100 mg three times a day, lisinopril 5 mg daily, metoprolol succinate extended release (ER) 50 mg daily, Xarelto 20 mg daily at dinner, and divalproex sodium 1500 mg daily at bedtime. On August 28, 2024, during a facility tour, the surveyor observed the following medications in the locked medication cabinet located in the kitchen for R1: -four seven day pill set up boxes with multiple unidentified medications, one card of acetaminophen 500 mg, two cards fluoxetine 40 mg, six cards of gabapentin 100 mg, one card of metoprolol succinate 50 mg, one card of lisinopril 5 mg, one card of atorvastatin 40 mg, two cards of Xarelto 20 mg, two cards of divalproex 500 mg, two albuterol inhalers, one fluticasone propionate nasal spray 50 mcg, two lidocaine viscous topical solution 2 %.	01910		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENEHANDS HOME HEALTH CARE	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01910	Continued From page 62 R2 R2 admitted to the licensee on November 2, 2022, and discharged on July 7, 2023. R2's diagnoses included major depressive disorder, generalized anxiety disorder, and intellectual disability. R2's unsigned Service Plan (Wavier) -Addendum to Contract with effective date of August 15, 2024, indicated R2 had received assistance with activities, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, and pain management. R2's Med Admin Summary - Month dated January 2023 included buspirone 10 mg three times per day, fluoxetine 30 mg daily, fluticasone 50 mcg nasal spray, gabapentin 300 mg three times per day, lorazepam 0.5 mg twice per day, metformin 50 mg twice per day, aripiprazole 10 mg at bed time, benzoyl peroxide 0.5 % at bed time, acetaminophen 325mg to 650 mg as needed (PRN) every six hours, diclofenac 2 grams (g) topically four times a day PRN, hydroxyzine 25 mg to 50 mg every four hours PRN, lorazepam 0.5 mg twice a day PRN. R2's Medication disposition dated February 28, 2023, to November 2, 2023, did not include any medication information. On August 28, 2024, at 12:16 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated medications were destroyed at a local pharmacy. LALD/CNS-C stated they dropped off the medication at the local pharmacy and documented the medications that were dropped off. LALD/CNS-C stated	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENEHANDS HOME HEALTH CARE	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01910	Continued From page 63 medications were normally disposed of within 10 weeks of being expired or after discharge. LALD/CNS-C stated they just kept R1's medications locked until they could "get to it" and there was no one currently living in the facility. On August 29, 2024, at 1:50 a.m., LALD/CNS-C stated R2's medications were destroyed, and they were unable to locate the documentation of the destruction. Although a medication management policy was requested, the surveyor did not receive a policy from the licensee prior to the completion of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36280	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENEHANDS HOME HEALTH CARE	5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
03090	Continued From page 64 potential to affect all current residents, staff, and visitors to the facility. 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 28, 2024, at 11:08 a.m., during a facility tour, the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On August 28, 2024, at 11:56 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee did not have an electronic monitoring posting. LALD/CNS-C stated they were aware of the requirement. LALD/CNS-C stated they have cameras in place at the facility and they provided the policy to the residents to give them a "heads up" that they were being monitored. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *08/28/24*
Time: 11:00:00
Report: 1051241097

Food and Beverage Establishment Inspection Report

Location:

Serenehands Home Health Care
5913 York Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038960
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633546045
ID #:

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

The following orders were issued during this inspection.

7-300 Toxic Retail Sale

7-301.11A ***** Priority 1 *****

MN Rule 4626.1680A Separate poisonous or toxic materials intended for retail sale from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

AT TIME OF INSPECTION, HAND SANITIZER BOTTLES, CHLORINE WIPES, DEODORANT STICKS, AND SHAMPOO WERE STORED ABOVE THE CAN OF FOODS IN THE PANTRY.

Comply By: 08/28/24

4-300 Equipment Numbers and Capacities

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

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

AT TIME OF INSPECTION, THERE WAS NO THIN-TIPPED THERMOMETER.

Comply By: 09/04/24

2-100 Supervision

2-102.12AMN

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

NO CFPM ON-SITE. SEND IN A STAFF TO TAKE AN APPROVED TRAINING COURSE. WITHIN 6 MONTHS OF PASSING THE COURSE, SUBMIT THE RESULTS WITH THE STATE APPLICATION TO OBTAIN CERTIFICATE.

Comply By: 09/28/24

Type: Full
Date: *08/28/24*
Time: 11:00:00
Report: 1051241097
Serenehands Home Health Care

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MAYO
Violation Issued: No

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

MET WITH NURSE EVALUATOR, ASHLEY CREWS.

DISCUSSED THE FOLLOWING WITH THE MANAGER, PRINCESS:

CERTIFIED FOOD PROTECTION MANAGER (APPLICATION SENT W/ REPORT)
EMPLOYEE ILLNESS LOG (FACT SHEET SENT W/ REPORT)
VOMIT CLEAN-UP PROCEDURE

THE KITCHEN HAS A NSF 184 DISHWASHER, LAMINATE COUNTERTOPS WITH HALLOW BASES, MDF WOODEN CABINETS, VINYL WOODEN FLOORS, AND SMOOTH TEXTURE CEILING.

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 1051241097 of 08/28/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Princess Smith
Manager

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us