Electronically delivered

August 18, 2023

Licensee
Caring Nurses LLC
7700 Shingle Creek Drive
Brooklyn Center, MN 55443

RE: Project Number(s) SL31336015

Dear Licensee:

On August 1, 2023, 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 May 3, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 3, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on May 3, 2023, found not corrected at the time of the August 1, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f)

details of the violations noted at the time of this follow-up survey completed on August 1, 2023 (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 and enforcement actions 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.

IMPOSITION OF FINES:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at .

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,

Jess Schoenecker's Supervisor
State Rapid Response Team / State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: Fax: 651-215-6894 / 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	R 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments INITIAL COMMENTS: Project # SL31336015-1 On August 1, 2023, he Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on May 2, 2023. As a result of the revisit, the following order(s) were reissued and/or issued.	{0 000}		
{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: No further action required.	{0 480}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time	{0 580}		

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{0 580}	Continued From page 1 of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: No further action required.	{0 580}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further action required.	{0 640}		
{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;	{0 680}		

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{0 680}	Continued From page 2 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}		
{0 810} SS=C	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	{0 810}		

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{0 810}	Continued From page 3 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the required resident fire protection procedures as part of the fire safety and evacuation plan and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level 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:	{0 810}		

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{0 810}	Continued From page 4 On August 1, 2023, from approximately, 3:00 p.m. to 3:30 p.m., document review and interview with the director of maintenance (DM)-G on the home's fire safety and evacuation documentation, the evacuation drill records, and related employee and resident training documentation indicated the following: -No documentation on fire protection procedures for residents. In addition, no documentation and/or records to show training of residents that can self-assist in their evacuation during the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. The DM-G indicated that the residents participated in the fire drills but no records of residents attendance were provided for review. -Documentation and/or records showed the licensee failed to meet the period of correction required of 14 days to carry out employee evacuation drills as outlined in state correction orders issued on June 1, 2023 (electronically delivered). One drill record provided for the review was July 25, 2023 (with no time documented) which was approximately 55 days after the state correction orders were issued. The DM-G indicated she recently inherited this task. On August 1, 2023, at 3:30 p.m., during the interview, the DM-G acknowledged the above findings. No further information was provided.	{0 810}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an	{01440}		

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{01440}	Continued From page 5 appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	{01530}		

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{01530}	Continued From page 6 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}		

Electronically Delivered

June 1, 2023

Licensee
Caring Nurses LLC
7700 Shingle Creek Drive
Brooklyn Center, MN 55443

RE: Project Number(s) SL31336015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 3, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL31336015 On May 2, 2023, through May 3, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 active residents receiving services under the Assisted Living license. On May 3, 2023, the immediacy of correction order 0820 has been removed, however non-compliance remains at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 had the potential to affect all residents in the Assisted Living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated May 2, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident	0 580		

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0 580	Continued From page 2 services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. 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 an interview on May 2, 2023, at 10:55 a.m., licensed assisted living director (LALD)-C stated the licensee conducted a daily meeting with management to discuss any of the licensee's issues. LALD-C stated there was not a specific meeting to evaluate the quality of care by reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in	0 580		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 580	Continued From page 3 order to ensure safe and competent services to residents. LALD-C also stated the licensee did not keep documentation of the daily staff meetings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information to contact 911 emergency number in common areas and near telephones provided by the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 640		

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	31336	A. BUILDING: _____ B. WING _____	05/03/2023

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0 640	Continued From page 4 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 a building tour on May 2, 2023, at 10:45 a.m., the surveyor noted the facility's common areas had no posting of the 911 emergency number. During an interview on May 3, 2023, at 11:35 a.m., registered nurse (RN)-A stated she believed the information was posted and RN-A stated she was not aware there was no information about 911 posted. The licensee's Emergency/911 policy dated August 1, 2021, identified the procedure to contact 911 emergency services in the event of an emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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;	0 680		

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0 680	Continued From page 5 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency disaster plan (EDP) containing all the requirements outlined in Appendix Z and posted prominently. 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: During the entrance conference on May 2, 2023, at 10:15 a.m., licensed assisted living director (LALD)-C stated the licensee had an EDP binder.	0 680		

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0 680	Continued From page 6 During record review on May 2, 2023, at 12:05 p.m., the licensee's EDP lacked the following components: - post an emergency disaster plan prominently; - post emergency exit diagrams on all floors; - program patient population; - subsistence needs for staff and residents; -tracking staff and residents; -volunteer policies and procedures; -roles under a waiver declared by Secretary; -communication plan; -sharing information occupancy needs; -family notifications; - blank form, no forms in resident records; -emergency prep testing requirements; - blank test form in binder; and - no tests in staff training records. During interview on May 3, 2023, at 11:05 a.m., LALD-C stated she was not aware there wasn't an emergency evacuation plan posted in the licensee's building or that the licensee did not have the most up to date documentation regarding the licensee's emergency plan. LALD-C stated she did believe that all staff and all residents had been educated on the licensee's emergency evacuation plan but was unaware there was no documentation showing they received the education. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that would disrupt services. No further information was provided.	0 680		

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0 680	Continued From page 7 TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 680		
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, record review, and interview, the licensee failed to maintain and provide the minimum required size of portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 790		

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0 790	Continued From page 8 The findings include: On May 2, 2023, from 10:45 a.m. to 12:15 p.m., survey staff toured the home with the unlicensed personnel (ULP)-C. During the tour, survey staff observed and the ULP-C verified the following: 1. The portable fire extinguishers installed throughout the home did not meet the required minimum rated type, 2-A:10-B:C. Survey staff observed the label on the mounted units with the incorrect size unit with rating type 1-A:10-B:C. 2. The portable fire extinguishers were observed with no tags attached to indicate the required annual service and monthly inspections from this year, or any previous years. On May 2, 2023, at approximately 1:30 p.m., at the exit interview, the ULP-C acknowledged the above findings. The ULP-C agreed to replace all the small existing extinguishers with at least two new types of portable fire extinguishers with minimum rating type, 2-A:10-B:C, one for the main floor and one for the basement level floor. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800		

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0 800	Continued From page 9 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 are: On May 2, 2023, from 10:45 a.m. to 12:15 p.m., survey staff toured the home with the unlicensed personnel (ULP)-C. During the tour, survey staff observed and the ULP-C verified the following: 1. Resident room windows: - Bedroom #1-The ULP-C attempted and failed to open the large double-hung type egress window in resident room # 1 (unoccupied) on the main level for measurement. Four windows were missing the handle hardware and not openable, and the other window opened with an obstruction near the outside ramp bar and failed to open all the way. The ULP-C stated that the resident is at the hospital and will contact maintenance staff about the window handles. -Bedroom #5- The ULP-C attempted and failed to	0 800		

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0 800	Continued From page 10 open the large double-hung type egress windows in resident room # 5 (unoccupied) on the main level for measurement. The ULP-C agreed that the windows need to be repaired for immediate opening and use. -Bedroom #6- The window hardware for bedroom #6 was not easily and readily operable for immediate use. After multiple attempts by the ULP-C, the large double-hung window opened but the ULP-C was not able to close and secure the window again. In addition, the windows in bedroom # 6 failed to close tight to lock for safety and to maintain the room temperature for the resident's well-being. The ULP-C stated that she will have maintenance staff fix the windows to ensure easy operation and provide a tight fit to eliminate the air entering from the outside. 2. The light bulb inside the medication room in the basement was burned out. 3. The storage room in the basement under the stairway had a door when opened was partially blocked with storage supplies and not properly maintained free of obstructions to allow for a proper exit from inside the room. On May 2, 2023, at approximately 1:30 p.m., during the exit interview, survey staff explained to the ULP-C that all egress windows must be easily and readily operable for immediate use for the safety of residents. The ULP-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 11 (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. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the fire safety and evacuation plan, the required	0 810		

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0 810	Continued From page 12 employee and resident training on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and 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 May 2, 2023, at approximately 12:30 p.m., survey staff requested from the unlicensed personnel (ULP)-C for the home ' s fire safety and evacuation documentation, the evacuation drill records, and related employee and resident training documentation for review. The ULP-C stated that the floor plan layouts are posted but the requested documents were located off-site at their main office and will need to retrieve the document from there. At approximately, 1:15 p.m. survey staff reminded the ULP-C about the requested fire safety and evacuation plan and related documentation. At 1:30 p.m., interview with the ULP-C indicated no documentation or records were available or provided for the review and the licensee lacked: 1. The required fire safety and evacuation plan that is readily available at the home. The licensee is required to maintain accurate fire safety and emergency evacuation plan and is readily available on-site at the home.	0 810		

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0 810	Continued From page 13 2. The required documentation on employee actions to be taken in the event of a fire or similar emergency. 3. The procedures for resident movement for addressing evacuation, movement, and relocation, including unique or unusual resident needs during an evacuation. Unique situations may be residents who are wheelchair-bound, on walkers, bedridden, have cognitive impairment and need assistance during an evacuation which must be addressed in the documentation. 4. Documentation of fire protection procedures for residents. 5. Documentation and/or records of employee training on the fire safety and evacuation plan. The minimum required employee training is upon hire and twice a year. 6. Documentation and/or records to show training of residents that can self-assist in their evacuation during the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. 7. Documentation and/or records of required evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill every other month. On May 2, 2023, at 1:30 p.m., during the exit interview, survey staff explained to the ULP-C that the home ' s fire safety and evacuation plan must be readily available at the home, and required training and evacuation drills must be performed as required. The ULP-C acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen days (14) days	0 810		

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0 820	Continued From page 14	0 820		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under 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 home had double-keyed deadbolt hardware on the egress side of the home's exit doors. In addition, the egress windows for the occupied resident bedrooms #3 and #4 on the main floor were screwed into the window frames which did not allow the windows to be openable for egress. This had the potential to affect all residents, staff, and visitors because the timely evacuation of the home would not be possible in the event of a fire, hostile intruder, or other life-threatening emergencies. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	0 820	Dear MDH Official: In this letter, we wish to respond to elements of the Immediate Corrective Order issued on May 3, 2023. Please find our plans, including dates of completion below: [...] The home had double-keyed deadbolt hardware on the egress side of the home's exit doors. As of end-of-day May 2, 2023, the double deadbolt locks have been removed from the front and rear door at the location of the survey and replaced with a single sided deadbolt that does not require a key to open.	

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0 820	Continued From page 15 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 May 2, 2023, from 10:45 a.m. to 12:15 p.m., survey staff toured the home with the unlicensed personnel (ULP)-C. During the tour, survey staff observed and the ULP-C visually verified the following: At approximately 11:01 a.m., survey staff observed the front exit had double-keyed deadbolt hardware that required a key to lock and unlock the doors from the interior of the home. Survey staff asked the ULP-C about the double-keyed deadbolt hardware and if she could open the front door so survey staff can step outside of the home. The ULP-C stated that she needed to get the key to open the door and explained the key deadbolt on the front exit door was necessary to protect the resident in room #2 from elopement and crossing the busy street. After locating a set of keys, the ULP-C attempted to open the front door. After five minutes of using multiple sets of keys, the ULP-C was not able to open the front exit door. The ULP-C called the maintenance staff and at approximately, 11:45 a.m. (45 minutes later), the home's maintenance staff arrived, and survey staff was advised by the ULP-C that the front exit door has been opened using the correct key. At approximately 11:35 a.m., survey staff asked the ULP-C to open the windows in occupied resident rooms #3 and #4 on the main floor. The ULP-C was not able to open any of the windows	0 820	As of end-of-day May 2, 2023, the hardware that was preventing the windows from opening has been removed. The staff at the surveyed location have been notified of the change to the locks and spoken with about the importance of protecting egress routes. At no time in the future will any locks or mechanisms be used that will impede egress. We are conducting a full inspection of this and other licensed locations to ensure that all windows open easily and close securely. All locks will be able to be operated by any resident or staff without a key. The issues noted in the corrective order have already been remedied and our additional inspections and any consequent modifications will be completed by 5/5/23. Sincerely, Edward J. Stronge Operations Manager, Caring Nurses LLC	

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0 820	Continued From page 16 in the bedrooms after multiple attempts. Survey staff and the ULP-C observed two screws installed on the bottom of the windows preventing the windows from being opened. Survey staff explained to ULP-C that the evacuation of residents #3 and #4 is compromised due to the secondary egress windows in bedrooms #3 and #4 with the screws installed into the window frame preventing the window from being readily operable for immediate use. Both the home's primary and the secondary means of egress are comprised for resident rooms #3 and #4 and a timely evacuation of the residents would not be possible in the event of a fire or similar emergency. At approximately, 11:50 a.m., survey staff observed the back exit door also had a double-keyed deadbolt hardware that required a key to lock and unlock the doors from the interior of the home. The finding was evident as the blue-colored keyring with the door key was hanging from the deadbolt hardware. On May 2, 2023, at approximately 1:30 p.m., during the exit interview, survey staff explained to the ULP-C that a distinct hazard order was issued for the above findings. Survey staff explained to the ULP-C that the locks in the means of egress that require a key will cause delay and impediment in proper exiting of the home as well as the screwed-in egress windows preventing safe egress for resident rooms #3 and #4 during a fire or similar emergency and violate state codes. The ULP-C acknowledged the findings and agreed to address the immediacy by removing the double-keyed deadbolts and screws on the windows. No further information was provided.	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 17 TIME PERIOD FOR CORRECTION: Immediate On May 3, 2023, the immediacy of correction order 0820 has been removed, however non-compliance remains at a scope and level of l.	0 820		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing	01440		

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01440	Continued From page 18 delegated tasks within 30 days of providing services for one of one unlicensed personnel ((ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C had a hire date of November 1, 2016. ULP-C was hired to provide direct care and services to the licensee's residents. ULP-C's employee record lacked documentation of an RN supervising ULP-C performing delegated tasks within 30 days of providing delegated services. During an observation on May 3, 2023, at 12:05 p.m., ULP-C performed blood glucose monitoring and insulin administration to R1 as prescribed. During an interview on May 3, 2023, at 12:35 p.m., ULP-C stated RN-A had completed training with ULP-C on blood glucose monitoring and insulin administration. ULP-C stated they could not remember if they had been supervised on completing the delegated tasks. During an interview on May 3, 2023, at 1:20 p.m., registered nurse (RN)-A stated that she did not conduct official 30-day supervisory evaluations of ULPs performing delegated tasks; however, she did frequently observe ULP's to ensure they were completing tasks appropriately.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

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01440	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (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 one of one employee	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	05/03/2023

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01530	Continued From page 20 (registered nurse (RN)-A) received the required amount of dementia care training in the required time frame. 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: RN-A had a hire date of April 3, 2023. RN-A's employee record contained zero hours of dementia training and lacked the required eight (8) hours of dementia training within 120 working hours of the employment start date. During an interview on May 2, 2023, at 1:15 p.m., licensed assisted living director (LALD)-C stated RN-A had been employed since April 3, 2023, and worked on average forty hours per week since start of employment. LALD-C stated all employees received dementia training through an online education system. LALD-C stated the licensee specifically contracted with this online education system to ensure that all new employees would receive eight hours of dementia training upon hire. The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated direct care staff would complete eight hours of initial training in dementia care within one hundred twenty hours of employment start date.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

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01530	Continued From page 21 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *05/02/23*
Time: 11:49:53
Report: 1029231102

Food and Beverage Establishment Inspection Report

Location:
Caring Nurses Llc
7700 Shingle Creek Drive
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038418
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635664325
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Multiple TCS items observed in refrigerator to be temperature abused. Discarded. Instructed establishment to discard any other TCS temp abused food, adjust refrigerator, and verify proper temps before placing any more TCS foods in.

Comply By: 05/02/23

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

Date marking missing from opened deli meat in refrigerator. Instructed establishment to date mark items.

Comply By: 05/02/23

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

No method present to test max temp in dishwasher. Instructed establishment to obtain temp stickers or min/max thermometer to verify NSF dishwasher sanitizing temperatures.

Comply By: 05/12/23

2-100 Supervision

2-102.12AMN

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

No evidence of CFPM employed by establishment. Instructed establishment to employ CFPM. Establishment indicated they currently have two people in training to obtain CFPM certification.

Comply By: 05/02/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Handwashing sign not present at handwashing sink. Instructed establishment to post handwashing sign.

Comply By: 05/02/23

Food and Equipment Temperatures

Process/Item: milk
Temperature: 48 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: sliced ham
Temperature: 45 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: sliced turkey
Temperature: 43 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: mayonnaise
Temperature: 45 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: shell eggs
Temperature: 48 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

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

Conducted inspection of food services area as part of a Health Regulation Division ("HRD") survey.

Conducted inspection in the presence of Joice Garty, House Manager - Person in Charge, other staff members, and residents. All identified issues were discussed with Joice during and after the inspection. Topics also discussed with Joice included employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, sanitizing, common contagious foodborne illness pathogens (e.g., salmonella, shigella, Shiga toxin-producing E. coli, hepatitis A virus, and norovirus), hygienic practices (e.g., handwashing), and general food safety practices (e.g., holding temperatures at or below 41°F and 135°F or above for TCS

foods).

Date marking, cooking and holding temperatures, and certified food protection manager information sheets were emailed to Joice during the inspection.

Kitchen had laminate wood flooring, smooth painted walls and ceiling, laminate countertops, and composite wood cabinetry with laminate covering. Minor damage observed on floor and wall near the refrigerator. Gap between counter and wall behind main sink. Kitchen was in fair condition.

The inspection findings were discussed with Lead HRD Surveyor, Elyse Jones, RN Nurse Evaluator 2, following the inspection.

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 1029231102 of 05/02/23.

Certified Food Protection Manager: Vacant

Certification Number: _____ Expires: / /

Signed: _____

Joice Garty
House Manager

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231102

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	4	**Date**	05/02/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:49:53
Legal Authority MN Rules Chapter 4626		**Time Out**	

Caring Nurses Llc	**Address** 7700 Shingle Creek Drive	**City/State** Brooklyn Park, MN	**Zip Code** 55443	**Telephone** 7635664325
License/Permit # 0038418	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) [signature] **Date:** 05/02/23

Inspector (Signature) [signature]