Electronically Delivered

December 13, 2024

Licensee
Caring Group Home LLC
1318 Emerson Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL37107015

Dear Licensee:

On October 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 7, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

September 12, 2024

Licensee
Caring Group Home LLC
1318 Emerson Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL37107015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Amy Hyers, Regional Operations Manager
State Evaluation Team
Email:amy.hyers@state.mn.us

Telephone: 651-443-2878 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37107	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING GROUP HOME LLC	1318 EMERSON AVENUE NORTH MINNEAPOLIS, MN 55411

(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(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: SL37107015-0 On August 5, 2024, through August 7, 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 four residents; four receiving services under the provider's provisional Assisted Living Facility license. An immediate correction order was identified on August 6, 2024, issued for SL37107015-0, tag identification 0820. On August 7, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
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 had the potential to affect all residents of 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 (FBEIR), dated August 6, 2024, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 2 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 780		

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0 780	Continued From page 3 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 6, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with housing manager (HM)-B. Survey staff asked HM-B to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. On August 6, 2024, at 1:30 p.m., HM-B stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 4 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 August 6, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with housing manager (HM)-B. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. On August 6, 2024, at 1:30 p.m., survey staff explained to HM-B that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated	0 790		

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0 790	Continued From page 5 location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. HM-B stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 800		

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0 800	Continued From page 6 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 6, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with housing manager (HM)-B. The following was observed: GENERAL MAINTENANCE: The basement bathroom had a hole in the ceiling and the sealant at the base of the toilet was cracking and heavily stained. The outlet next to the toilet had significant gapping around the outlet cover exposing the wall cavity and wiring to water penetration. EGRESS WINDOWS: The egress window in bsement bedroom 4 had a soft screen material and hard plastic snow shield obstructing the window well. On August 6, 2024, at 1:30 p.m., HM-B stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 7 (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, 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	0 810		

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0 810	Continued From page 8 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: On August 6, 2024, house manager (HM)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "9.06 Fire Policy", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810		

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0 810	Continued From page 9 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On August 6, 2024, at 1:30 p.m., HM-B stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. HM-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records, titled "Fire Safety Training, Natural Disaster, and Evacuation Plan", undated, indicated staff was trained one time per year. No other training documentation was provided. On August 6, 2024, at 1:30 p.m., HM-B stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements.	0 810		

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0 810	Continued From page 10 DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of the licensee's evacuation drill log, titled "Fire Drill Log", undated, indicated evacuation drills were conducted on August 12, 2021, September 19, 2022, December 28, 2022, March 1, 2023, March 21, 2023, August 12, 2023, and January 1, 2024. No other documentation was provided. On August 6, 2024, at 1:30 p.m., HM-B stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be 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:	0 820		

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0 820	Continued From page 11 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 some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 6, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with housing manager (HM)-B. During the tour, survey staff asked HM-B to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 4: One window measuring 24 3/4 inches clear width, 16 1/2 inches clear height, and 408 square inches total open area. The window in bedroom 4 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.	0 820	This immediate correction order identified on August 5, 2024, has had the immediacy lifted as of August 7, 2024, however non-compliance remained a scope and level of G.	

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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
0 820	Continued From page 12 Survey staff explained to HM-B 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. On August 6, 2024, survey staff explained to HM-B that an immediate correction order was issued for the above findings. HM-B stated they understood the requirements for egress windows. TIME PERIOD FOR CORRECTION: Immediate. DOOR LOCKING: On the same facility tour on August 6, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff observed a heavy-duty slide lock installed near the top of the door. Required exit doors in this type of facility are allowed to be provided with one security type lock (2 locking devices total) such as the deadbolt, in addition to the door latch lock and installed not more than 48 inches from the floor. HM-B removed the slide lock at the time of the survey. On August 6, 2024, HM-B stated they understood the exit doors could not have extra locks in addition to a standard latch and deadbolt with a thumb turn. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	01500		

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	37107	A. BUILDING: _____ B. WING _____	08/07/2024

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01500	Continued From page 13 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01500		

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01500	Continued From page 14 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired May 3, 2021, and provided direct care services to residents. On August 5, 2024, at 12:05 p.m., ULP-D was observed to assist R2 with medication administration.	01500		

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01500	Continued From page 15 ULP-D's record indicated annual training was last completed May 2, 2023. The training lacked: -The principles of person-centered planning and service delivery. ULP-D's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: -The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 5, 2024, at 1:11 p.m., ULP-D stated he had annual training, but it had been a while since he had it last. ULP-D provided his Educare (online training program) transcript and stated his last training was completed May 1, 2023. On August 5, 2024, at 1:29 p.m., administrator (A)-B stated annual training was due to be completed on the employee's anniversary date, but ULP-D was on a vacation for about three weeks in May when his annual training was due. A-B stated he was not sure why the person-centered care topic was not included in the annual training. On August 6, 2024, at 9:29 a.m., clinical nursing supervisor (CNS)-A stated she typically reviewed employee files monthly, but ULP-D was off work at the time his annual training was due, so that could be why it was missed. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated, "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of	01500		

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01500	Continued From page 16 vulnerable adults under section 626.557; 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940		

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01940	Continued From page 17 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) receiving treatment services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01940		

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01940	Continued From page 18 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 had diagnoses including bipolar disorder, post-traumatic stress disorder, anxiety, substance abuse, and major depressive disorder. On August 5, 2024, at 10:57 a.m., administrator (A)-B stated R2 had a walking boot that she needed assistance with as needed (PRN). R2's record included a provider order dated May 21, 2024, that indicated, "tall CAM [controlled ankle movement] boot size M". R2's service plan dated April 10, 2023, indicated R2 received services including assistance with medication management, housekeeping, laundry, and reminders and standby assistance as needed for showering and grooming. The service plan lacked any information related to assistance with a CAM boot. R2's record lacked a treatment management plan related to R2's CAM walking boot, including: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940		

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01940	Continued From page 19 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 5, 2024, at 2:26 p.m., ULP-D stated he helped R2 with putting on the CAM boot initially, but R2 was independently wearing the boot now. ULP-D stated he thought staff was trained on how to put the boot on, but he did not personally recall being trained. ULP-D further stated he used to wear a similar boot, so remembered how to properly wear it. On August 5, 2024, at approximately 3:15 p.m., R2 stated staff assisted her with putting on the CAM boot if she needed help. On August 6, 2024, at 9:23 a.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A stated R2 had the boot for about a month, and took care of it herself. LALD/CNS-A further stated she instructed staff to provide standby assistance to R2, and R2 wanted to maintain her independence. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated, "For each resident at Caring Group Home receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. 1. Caring Group Home will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will	01940		

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01940	Continued From page 20 be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. 2. The treatment or therapy management record must be current and updated when there are any changes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed	01950		

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01950	Continued From page 21 personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) instructed and ensured competency of the unlicensed personnel (ULP) on proper treatment procedures, specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record 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: ULP-D was hired May 3, 2021, and provided direct care services to residents. R2 had diagnoses including bipolar disorder, post-traumatic stress disorder, anxiety, substance abuse, and major depressive disorder.	01950		

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01950	Continued From page 22 R2's service plan dated April 10, 2023, indicated R2 received services including assistance with medication management, housekeeping, laundry, and reminders and standby assistance as needed for showering and grooming. The service plan lacked evidence of receiving assistance with treatments. R2's record included a provider order dated May 21, 2024, that indicated, "tall CAM [controlled ankle movement] boot size M". R2's record lacked any specific treatment instructions related to R2's CAM walking boot. On August 5, 2024, at 10:57 a.m., administrator (A)-B stated R2 had a walking boot that she needed assistance with as needed (PRN). On August 5, 2024, at 2:26 p.m. ULP-D stated he helped R2 with putting on the CAM boot initially, but R2 was independently wearing the boot now. ULP-D stated he thought staff was trained on how to put the boot on, but he did not personally recall being trained. ULP-D further stated he used to wear a similar boot, so he remembered how to properly wear it. On August 5, 2024, at approximately 3:15 p.m. R2 stated staff assisted her with putting on the CAM boot if she needed help. ULP-D's record lacked any evidence of training in procedures for assisting R2 with the CAM boot. On August 6, 2024, at 9:23 a.m. licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A stated R2 had the boot for about a month, and took care of it herself. LALD/CNS-A	01950		

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01950	Continued From page 23 further stated she instructed staff to provide standby assistance to R2, and R2 wanted to maintain her independence. The licensee's Orientation and Training policy dated August 1, 2021, indicated, "When a registered nurse or licensed health professional staff of Caring Group Home delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks." The policy further indicated additional nursing tasks that were frequently delegated to unlicensed personnel that would require training and competency testing by a RN included, but were not limited to the following: -Splints; -Leg braces; -Protective boots, soft casts, and inflatable boots; and -AFO (ankle-foot orthosis) Braces. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility.	02290		

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02290	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee established written house rules and regulations that used language which limited the rights for one of one resident (R2). This had the potential to affect all residents residing within the 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 of the residents). The findings include: On August 5, 2024, during a tour of the facility, the surveyor observed a sign near the front door of the facility, that indicated visiting hours were 8:00 a.m. to 8:00 p.m. R2's service plan, dated April 10, 2023, indicated R2 received services including assistance with medication management, housekeeping, laundry, and reminders and standby assistance as needed for showering and grooming. R2's record included House Rules for Clients, signed by R2 on April 10, 2023. The House Rules included: "-Residents are expected to keep their room neat and orderly. No laying on the couch at any time. No pillows or blankets are allowed outside of the bedroom at any time. -Eating is permitted in the dining room only. All trash, crumbs, etc. will be cleaned up immediately	02290		

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02290	Continued From page 25 after eating. All dishes, pots, pans, silverware, etc. will be washed, dried, and put away immediately after eating. -Care givers will be available in helping you achieve this expectation. -Residents are not allowed in any other bedroom or apartment but their own. NO EXCEPTIONS!! -Respect and care should be shown at all times towards guests and all members. Each member is responsible for the conduct of his/her guest. Residents are asked to be respectful with the phone by limiting their calls to 15 minutes. No phone calls during sleep hours. -Physical or verbal threats will not be tolerated. Any such instance will result in discharge. The same applies to stealing, destruction of property (Charges may be tiled (sic).). -No weapons of any kind are allowed on [licensee]. Chemicals and knives will be in a locked cabinet and can only be accessed with a staff permission. -Residents are not allowed to fraternize, flirt, or engage in any sexual or intimate relationships, behavior, or language with each other while in [licensee]. -Residents must sign out once they get out of [licensee] facility and sign back in when they get back to the residence. Per DHS [Minnesota Department of Human Services] policy, residents have to officially check in within 24-hours beginning from the minute they leave the facility. This will otherwise lead to a missing person report to MAARC [Minnesota Adult Abuse Reporting Center]. -No resident should be out of the facility past 8pm. -Visitation hours are from 08:00am to 07:00pm. -Quiet hours are 10:00pm to 6:00am, radios and stereos may be played at a level not to be heard outside of that room. Lights on common areas will	02290		

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CARING GROUP HOME LLC	1318 EMERSON AVENUE NORTH MINNEAPOLIS, MN 55411

(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
02290	Continued From page 26 be turned off during these hours. -Alarms will be set by 10pm and all residents should be in their rooms. -Orders for breakfast, lunch and dinner should be provided one day before." On August 5, 2024, at 1:59 p.m., unlicensed personnel (ULP)-D stated visiting hours were 8:00 a.m. to 8:00 p.m., but sometimes they would let R2's children stay an extra 30 minutes, if needed. On August 5, at approximately 3:15 p.m., R2 stated the visiting hours are until 8:00 p.m., and her children knew they could not visit after that time. On August 5, at approximately 4:00 p.m., administrator (A)-B stated they had rules like visiting hours in place to protect residents, and did not consider it could be a restriction of rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

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

Type: Full
Date: *08/06/24*
Time: 10:00:00
Report: 1005241175

Food and Beverage Establishment Inspection Report

Location:
Caring Group Home Llc
1318 Emerson Avenue North
Minneapolis, MN55411
Hennepin County, 27

Establishment Info:
ID #: 0038991
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526498836
ID #:

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

The following orders were issued during this inspection.

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

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

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

IN THE INSIGNIA REFRIGERATOR, RAW SHELL EGGS WERE STORED OVER STRAWBERRIES AND TOMATOES. KEEP EGGS AND OTHER RAW ANIMALS FOODS BELOW READY-TO-EAT FOODS.

Comply By: 08/06/24

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

DISHES ARE BEING WASHED AND RINSED IN A SINGLE SINK BASIN, AND ARE NOT BEING SANITIZED. USE DISHWASHER TO WASH, RINSE, AND SANITIZE DISHES. SEE COMMENTS.

Comply By: 08/06/24

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.

THE ONLY FOOD THERMOMETER ON SITE WAS A LASER THERMOMETER. PROVIDE A THERMOMETER WITH A PROBE, SO THE INTERNAL TEMPERATURE OF FOODS CAN BE TAKEN.

Comply By: 08/13/24

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.

THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.

Comply By: 08/13/24

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO TOWELS WERE AVAILABLE AT THE HANDWASHING SINK IN THE KITCHEN. CORRECTED ON SITE.

Comply By: 08/06/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

THERE WAS NO AMBIENT THERMOMETER IN THE "GE" REFRIGERATOR. CORRECTED ON SITE.

Comply By: 08/06/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 170+ Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/POTATO SALAD
Temperature: 39 Degrees Fahrenheit - Location: INSIGNIA REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/SOUR CREAM
Temperature: 39 Degrees Fahrenheit - Location: INSIGNIA REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CHICKEN
Temperature: 36 Degrees Fahrenheit - Location: GE REFRIGERATOR
Violation Issued: No

Type: Full
Date: *08/06/24*
Time: 10:00:00
Report: 1005241175
Caring Group Home Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/CHEESE
Temperature: 37 Degrees Fahrenheit - Location: GE REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH MANAGER AND EMAILED TO HRD NURSING EVALUATOR RENEE ANDERSON.

THERE IS A DISHWASHER ON SITE BUT IT WAS BLOCKED BY A REFRIGERATOR AND NOT IN USE. DISCUSSED THAT DISHES NEED TO BE WASHED, RINSED, AND SANITIZED IN EITHER A 3-COMPARTMENT SINK OR A DISHWASHER. STAFF SAID THEY WILL MOVE FRIDGE AND USE THE DISHWASHER.

INSPECTOR LEFT THERMOLABELS ON SITE AND AFTER INSPECTION OPERATOR SENT INSPECTOR A PICTURE OF THE TEMPERATURE STRIP THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 170+ DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

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

FLOORING IS TILE, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE TILE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241175 of 08/06/24.

Certified Food Protection Manager: CABDICASIS S. MAHAMED

Certification Number: FM114063 Expires: 12/06/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
ABDIRASHID DEK
MANAGER

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us