Electronically Delivered

November 18, 2024

Licensee
Comfort Care Homes
2018 Upton Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL34809015

Dear Licensee:

On October 16, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 24, 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,

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

HHH

Electronically Delivered

August 20, 2024

Licensee
Comfort Care Homes
2018 Upton Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL34809015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $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 MDH within 15 calendar days of the correction order receipt date.

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34809	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE HOMES	2018 UPTON 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: SL34809015-0 On July 17, 2024, through, July 24, 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 (4) residents receiving services under the provider's Assisted Living Facility license. On July 18, 2024, an immediate correction order was issued for tag identification 1290. The immediacy of the order was removed effective July 22, 2024. Non-compliance remains and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 18, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 2 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document completion of a baseline tuberculosis (TB) screening for one of two unlicensed personnel ((ULP)-A). 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-A was hired on August 7, 2020. ULP-A's [health facility] Minute Clinic document dated June 21, 2022, indicated ULP-A had a TB Test (also called Tuberculin skin test (TST) or Mantoux) placed on June 21, 2022, with a	0 660		

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0 660	Continued From page 3 negative result read on June 24, 2022. ULP-A's record lacked a second step Mantoux test as required for all health care workers (HCW). On July 18, 2024, at 8:45 a.m., clinical nurse supervisor (CNS)-C stated the licensee failed to ensure ULP-A had a second step Mantoux. CNS-C stated all employees were required to have a two-step Mantoux or results from a TB screening blood draw in their record. CNS-C stated ULP-A had a blood draw recently, but CNS-C was unsure if the blood draw was related to a TB test. The licensee's Facility TB Risk Assessment Worksheet for Healthcare Settings Licensed by MDH (Minnesota Department of Health) dated March 3, 2024, failed to indicate if baseline TB screenings were required to be completed for employees at the time of hire, and failed to indicate if the licensee contacted MDH if the licensee did not require TB screening at the time of hire. The licensee failed to provide a policy or procedure related to employee TB screenings when requested. The Minnesota Department of Health's Resources & Frequently-Asked Questions (FAQs) website last updated April 3, 2024, read, "Baseline TB screening includes: assessing for current symptoms of active TB disease; assessing TB history; testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test."	0 660		

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0 660	Continued From page 4 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or 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	0 780		

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0 780	Continued From page 5 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 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 July 17, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with clinical nurse supervisor (CNS)-C and unlicensed personnel (ULP)-A. Survey staff asked ULP-A to initiate a test of the smoke alarms throughout the home. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: 1. Bedroom 1 smoke alarm was not interconnected with the rest of the home. 2. Bedroom 4 smoke alarm sounded when tested, but was chirping to indicate a low battery. These deficient conditions were visually verified by CNS-C and ULP-A accompanying on the tour. On July 17, 2024, at 2:30 p.m., CNS-C and ULP-A stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 780		

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0 780	Continued From page 6 days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. 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 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 July 17, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with	0 800		

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0 800	Continued From page 7 clinical nurse supervisor (CNS)-C and unlicensed personnel (ULP)-A. The following was observed. SMOKING AREAS: The designated smoking areas was not provided with a fire-rated ashtray. The residents were using a plastic flowerpot as an ashtray. Survey staff explained to CNS-C and ULP-A that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a fire hazard if cigarettes were not completely extinguished before discarding them. GENERAL MAINTENANCE: The wall next to the bathroom on the main level had a hole in exposing the wall cavity to the room. On July 17, 2024, at 2:30 p.m., CNS-C and ULP-A 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; (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	0 810		

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0 810	Continued From page 8 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 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).	0 810		

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0 810	Continued From page 9 The findings include: On July 17, 2024, unlicensed personnel (ULP)-A and clinical nurse supervisor (CNS)-C 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 "Fire Safety", dated December 7, 2023, 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 provided FSEP was from a third-party provider and had not been updated to the specific facility. 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. 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 July 17, 2024, at 2:30 p.m., CNS-C stated they understood the areas of their policy that were incomplete and would work on bringing	0 810		

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0 810	Continued From page 10 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. CNS-C 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 "Staff Fire and Emergency Safety Training Log", undated, indicated staff were trained upon hire and once per year. No other training documentation was provided. On June 17, 2024, at 2:30 p.m., CNS-C stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. 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 licensee's evacuation drill log, titled "Fire Drills", undated, indicated evacuation drills were conducted on September 8, 2023, July 3, 2023, June 6, 2023, and March 3, 2023. No other documentation was provided. On July 17, 2024, at 2:30 p.m., CNS-C stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 11 (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current background study (BGS) was completed for one of one employee (unlicensed personnel (ULP)-A) and was affiliated with the licensee's current assisted living facility health facility identification (HFID) number for one of one employee (ULP-B). 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large	01290		

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	34809	A. BUILDING: _____ B. WING _____	07/24/2024

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01290	Continued From page 12 portion or all of the residents). The findings include: The licensee's HFID was 34809. ULP-A ULP-A was hired on August 7, 2020, during the COVID-19 Emergency BGS waiver. ULP-A's Department of Human Services (DHS) BGS clearance letter dated November 11, 2021, indicated ULP-A's BGS was affiliated with HFID 32851. On July 17, 2024, at 12:22 p.m., clinical nurse supervisor (CNS)-C emailed the surveyor an untitled and undated document and indicated the document was the licensee's current DHS NetStudy 2.0 employee roster which listed all employees currently affiliated with the licensee's HFID. The roster lacked identification ULP-A was affiliated with licensee's HFID and had a cleared BGS. The DHS NetStudy 2.0 screenshot dated July 18, 2024, at 9:36 a.m., indicated ULP-A was affiliated with HFID 34809 on July 17, 2024, after the initiation of licensee's current survey and required supervision as ULP-A lacked fingerprinting as required for a cleared BGS. ULP-A's record lacked evidence of a cleared BGS. ULP-B ULP-B was hired on August 7, 2020, during the COVID-19 Emergency BGS waiver. ULP-B's DHS BGS clearance letter dated August	01290		

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01290	Continued From page 13 7, 2020, indicated ULP-A's BGS was affiliated with HFID 32851. On July 17, 2024, at 12:22 p.m., CNS-C emailed the surveyor an untitled and undated document and indicated the document was the licensee's current DHS NetStudy 2.0 employee roster which listed all employees currently affiliated with the licensee's HFID. The roster lacked identification ULP-B was affiliated with licensee's HFID and had a cleared BGS. The DHS NetStudy 2.0 screenshot dated July 18, 2024, at 9:44 a.m., indicated ULP-B had a cleared and affiliated BGS with a home care company CNS-C owned and operated. The DHS NetStudy 2.0 screenshot dated July 18, 2024, at 9:45 a.m., indicated the licensee had affiliated ULP-B with HFID 34809 on July 17, 2024, after the initiation of the licensee's current survey. ULP-B's record lacked evidence of a cleared BGS affiliated with the licensee's HFID. On July 18, 2024, at 9:10 a.m., CNS-C stated on July 17, 2024, after the initiation of the licensee's current survey, the licensee attempted to affiliate ULP-A and ULP-B with the licensee's current HFID but were unsuccessful as both ULP-A and ULP-B had expired COVID-19 BGS which lacked fingerprinting to verify identify. CNS-C stated both ULP-A and ULP-B were previously affiliated with the licensee's previous HFID 32851 prior to conversion to the current assisted living license HFID 34809. CNS-C stated ULP-A and ULP-B were both sent on July 18, 2024, to get fingerprinting completed in order to complete the clearance and affiliation to the licensee's HFID	01290		

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01290	Continued From page 14 and obtain BGS clearance letter for each. The DHS Emergency Background Studies End website accessed July 18, 2024, at 10:22 a.m., indicated COVID-19 emergency studies were no longer valid and all employees who had an emergency study would require a new study be completed with fingerprints as of January 1, 2023. The licensee's undated Background Studies policy lacked identification employee BGS would be completed within DHS's Netstudy 2.0 system and lacked identification each employee would be affiliated with licensee's HFID. No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was removed effective July 22, 2024. Non-compliance remains and the scope and level remain unchanged.	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 15 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident reassessment not to exceed 90 calendar days from the previous assessment for one of one resident (R1). 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: R1 was admitted on August 24, 2020. R1's Service Plan (Waiver) - Addendum to Contract with effective date August 21, 2022, read under the section Monitoring and Assessments, "Ongoing resident reassessment and monitoring must be conducted as needed basis on changes in the needs of the resident and	01620		

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01620	Continued From page 16 cannot exceed 90 calendar days from the last date of the assessment." R1's [licensee] Uniform Assessment Tool form dated April 1, 2023, and on page 18 or 19 included 90-Day Assessments review dated June 29, 2023, was identified by clinical nurse supervisor (CNS)-C as R1's most recent assessment. A total of 385 days had passed since the date of the last assessment. On July 17, 2024, at 9:00 a.m., during the entrance conference, CNS-C stated the licensee would complete assessments not to exceed 90 days from the previous assessment and would include all content as required. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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01730	Continued From page 17 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R1). 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	01730		

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01730	Continued From page 18 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on August 24, 2020. R1's Service Plan (Waiver) - Addendum to Contract with effective date August 21, 2022, indicated R1 required Medication Administration and Medication Setup services. R1's [licensee] Uniform Assessment Tool form dated April 1, 2023, and included 90-Day Assessment review dated June 29, 2023, was identified by clinical nurse supervisor (CNS)-C as R1's most recent assessment. R1's medication management record failed to include the following required content: -Type of storage system; -Person to monitor for refills; -Delegated tasks; and -Resident specific requirements. On July 18, 2024, at 9:45 a.m., CNS-C stated the licensee failed to fully complete the licensee's Uniform Assessment Tool form which would have contained all required content. CNS-C stated licensee was not sure why the Uniform Assessment Tool form was incomplete but would need to audit each resident's record to ensure each assessment was completed with all required content for the medication management record. The licensee's 7.03 Medication Management Individualized Plan dated August 1, 2021, indicated all required content for a medication management record and one would be created for each resident who received medication	01730		

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01730	Continued From page 19 management services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of one resident (R1) who received medication management. 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	01760		

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01760	Continued From page 20 or has the potential to affect a large portion or all of the residents). The findings include: On July 17, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-A provide medication administration to R1. ULP-A provided R1 their morning medications as packaged in medication cards. ULP-A popped out each medication after comparing each medication to R1's medication administration record (MAR). ULP-A provided R1 with the medications. R1 was admitted on August 24, 2020. R1's Service Plan (Waiver) - Addendum to Contract with effective date August 21, 2022, indicated R1 required medication administration and medication setup services. On July 18, 2024, at 9:20 a.m., clinical nurse supervisor (CNS)-C provided R1's Med Admin Summary - Actual - Month (MAS and also commonly referred to as a MAR) printed July 18, 2024, and indicated the document would be evidence of all medication administration provided to R1. R1's MAR lacked documentation ULP-A administered R1's morning medications as observed. Additionally, R1's MAR lacked documentation on July 1, 3, 4, 5, 8, 9, 10, 15, and 16, 2024 of medication administration or reason medications were not administered. CNS-C stated licensee was not sure why multiple days of R1's MAR lacked documentation. CNS-C state they were to be notified if any medications were not administered to any resident and licensee would need to investigate why employees did not document or contact CNS-C if medications were not administered as ordered. CNS-C stated	01760		

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01760	Continued From page 21 ULP-A should have documented the moment they administered R1's medications that morning and licensee would need to provide education to ULP-A to ensure they followed licensee's policy and procedure. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated all administration of medications were to be immediately documented and any refusal of medications would require evidence the licensee discussed possible consequences of the refusal. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were maintained for one of one resident (R1). 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	01820		

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01820	Continued From page 22 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 July 18, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-A provide medication administration to R1. ULP-A provided R1 their morning medications as packaged in medication cards. ULP-A popped out each medication after comparing each medication to R1's medication administration record (MAR). ULP-A provided R1 with the medications. R1 was admitted on August 24, 2020. R1's Service Plan (Waiver) - Addendum to Contract with effective date August 21, 2022, indicated R1 required medication administration and medication setup services. R1's [licensee] Uniform Assessment Tool form dated April 1, 2023, read under the Review of Medications section, "See Med (medication) list." R1's Med Admin Summary - Actual - month dated July 2024, indicated the licensee provided R1 medication administration two times per day. R1's medical record lacked written or electronically recorded prescriber's orders. On July 18, 2024, at 9:35 a.m., clinical nurse supervisor (CNS)-C stated licensee had not maintained copies of signed prescription orders for medications licensee administered. CNS-C stated licensee believed R1's pharmacy maintained current orders and the licensee would not need to have copies since the pharmacy	01820		

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01820	Continued From page 23 would maintain them. CNS-C stated pharmacy would be contacted to obtain copies of the current medications and would contact R1's primary care provider to verify all current orders. The licensee's 7.20 Medication & Treatment Orders policy indicated the licensee would maintain current authorized prescriber orders prior to implementation of medication administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of one resident (R2) with medication management 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01880		

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01880	Continued From page 24 a large portion or all of the residents). The findings include: On July 17, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-A open a secured metal file cabinet which contained all resident medications and was located in what would commonly be referred to as a living room. The living room was part of a great room designed main level where the living room, dining room, and kitchen were all one continuous open space used and accessed by all staff, residents, and visitors. While the metal file cabinet was unsecured and accessible to any resident or visitor in the facility, ULP-A left the area with no staff present to ensure medication safety during the following times: - At 7:48 a.m., ULP-A proceeded to the bathroom and closed the door behind themselves and returned to the living room area at 7:53 a.m.; and - At 8:01 a.m., ULP-A proceeded to the basement and returned to the common living room area at 8:05 a.m. On July 18, 2024, at 9:45 a.m., clinical nurse supervisor (CNS)-C stated licensee's expectations were the metal file cabinet with all resident medications was to be locked at all times unless staff were in direct line of sight of the cabinet. CNS-C stated ULP-A was trained to lock the cabinet when they were not actively providing medication administration to a resident. The licensee's 7.11 Medication Storage policy indicated all medications would be securely locked and only authorized staff would have access to the stored mediations. No further information provided.	01880		

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01880	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01880		
01940 SS=F	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 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34809	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE HOMES	2018 UPTON 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
01940	Continued From page 26 by: Based on observation, interview, and record review, the licensee failed to develop a treatment management record to include all required content for one of one resident (R1) with a treatment. 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 July 17, 2024, at 9:50 a.m., during a tour of the facility, R1's bedroom was noted to be in the basement and inside R1's bedroom an oxygen concentrator (a device which filtered and provided oxygen from room air) was noted with a nasal cannula tube leading from the concentrator to the side of R1's bed. R1 was admitted on August 24, 2020. R1's Service Plan (Waiver) - Addendum to Contract with effective date August 21, 2022, indicated R1 required the service of oxygen delivery daily. R1's [licensee] Uniform Assessment Tool form dated April 1, 2023, indicated under Treatments R1 required partial assist for checking oxygen and oxygen administration. The licensee's Minnesota Department of Health (MDH) Assisted Living Care Providers roster	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34809	A. BUILDING: _____ B. WING _____	07/24/2024

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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
01940	Continued From page 27 dated March 16, 2024, indicated R1 received oxygen treatment. R1's medical record lacked an individualized treatment/therapy management plan. On July 18, 2024, at 8:22 a.m., R1 stated they use the oxygen concentrator each night to help them sleep better and have used it every night and sometimes during the day when they felt short of breath. On July 18, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-C stated licensee failed to develop, implement, and maintain a treatment management record for R1's oxygen management. CNS-C stated licensee was under the impression R1 was no longer using oxygen and licensee failed to develop instructions and documentation related to R1's oxygen use. CNS-C stated licensee would need to complete an assessment, obtain current provider orders, and develop tracking for R1's oxygen use. The licensee's 7.15 Medication & Treatment - Administration & Delegation dated August 1, 2021, indicated when a resident required a treatment, the licensee would develop a treatment management record which would include all required content. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *07/18/24*
Time: 10:15:01
Report: 1023241141

Food and Beverage Establishment Inspection Report

Location:
Comfort Care Homes
2018 Upton Avenue North
Minneapolis, MN55411
Hennepin County, 27

Establishment Info:
ID #: 0038770
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6129782108
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.

OBSERVED RAW SHELL EGGS STORED OVER READY TO EAT FOODS SUCH AS DELI MEATS. OPERATOR MOVED EGGS TO SAFE LOCATION DURING INSPECTION.

Comply By: 07/18/24

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.

HIGH TEMP ANSI 184 DISH WASHER IN USE BUT OPERATOR NOT VERIFYING TEMPERATURE REACHES 150dF. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN ELIMINATION.

Comply By: 07/18/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *07/18/24*
Time: 10:15:01
Report: 1023241141
Comfort Care Homes

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/MILK
Temperature: Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

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 1023241141 of 07/18/24.

Certified Food Protection Manager: FATUMO ABDI

Certification Number: 111230 Expires: 12/11/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
DEKA
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us