Electronically Delivered

October 23, 2024

Licensee
St Jude Home Health LLC
6426 109th Place North
Champlin, MN 55316

RE: Project Number(s) SL36618015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 27, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	36618	A. BUILDING: _____ B. WING _____	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME HEALTH LLC	6426 109TH PLACE NORTH CHAMPLIN, MN 55316

(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: SL36618015-0 On September 23, 2024, through September 27, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four (4) residents; 4 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the staffing plan was evaluated twice yearly, to ensure sufficient staffing to meet the immediate and reasonably foreseeable unscheduled needs of each resident. This potentially affected all the licensee's current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 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 the residents). The findings include: On September 23, 2024, at approximately 11:00 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had a staffing plan that had been recently reviewed. On September 23, 2024, at approximately 1:00 p.m., the surveyor located the Home Staffing Plan dated November 9, 2023, in the licensee's Emergency Preparedness manual. The Home Staffing Plan included LALD/CNS-A's signature. On September 23, 2024, at approximately 1:00 p.m., LALD/CNS-A confirmed the Home Staffing Plan was the staffing plan for the facility and stated it was reviewed annually. LALD/CNS-A stated they had recently reviewed the plan but did not authenticate their review. The licensee's undated Minimum Assisted Living Facility Requirements policy stated the licensee would develop a staffing plan to determine sufficient staffing at all times to accommodate foreseeable unscheduled needs of its residents. The policy did not address frequency of review of the staffing plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 470		

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0 470	Continued From page 3 (21) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to posted grievance procedure in the common area to include all required information. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 550		

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0 550	Continued From page 4 the residents). The findings include: During a facility tour on September 23, 2024, at approximately 11:30 a.m., the surveyor noted the grievance process with all required information was not posted in the common area. On September 23, 2024, at approximately 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the grievance information was not posted and was likely located in a binder. On September 24, 2024, at approximately 1:20 p.m., LALD/CNS-A stated the information was given to residents upon admission and they were unaware of the requirement for posting grievance information in a common area. The licensee's 2.10 Complaint/Grievance Posting policy dated August 1, 2021, indicated [licensee] would post in a conspicuous place, information about the complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 5 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline TB testing for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: The licensee's Facility TB Risk Assessment form was completed July 2024, and identified the facility TB risk level as low.	0 660		

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0 660	Continued From page 6 ULP-B was hired on June 23, 2022, and began providing assisted living services. ULP-B's employee record included a TB history and symptom screen completed on June 17, 2022, and a negative T-SPOT TB test dated May 9, 2021. ULP-B's TB test was performed greater than 90 days pre-hire. On September 24, 2024, at approximately 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware TB tests were required to be performed within 90 days of hire or after hire and prior to working with residents. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated staff whose essential hob functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. No further information was provided.	0 660		

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0 660	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all	0 680		

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0 680	Continued From page 8 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, at approximately 1:00 p.m., the surveyor requested and was provided a manual titled Emergency Preparedness Plan. The licensee's EP plan, undated, lacked the following required content: -an annual review of the EP plan; -a facility and community-based hazard vulnerability assessment categorizing risk by likelihood of occurrence; -a quarterly review of the missing resident plan; -a process for collaboration with local, tribal, regional, State and Federal EP to maintain an integrated response; -policies and procedures to address food, water, medical, and pharmaceutical supplies for staff/residents whether evacuated or sheltered in place; -policies and procedures to address safe evacuation from the facility; -policies and procedures for sheltering in place; -a system to track the location on on-duty staff and sheltered residents; -policies for medical documentation that preserves resident information, protects confidentiality, and maintains availability of	0 680		

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0 680	Continued From page 9 records; -policies addressing the use of volunteers and the process/role for integration; -policies for providing care at alternate sites under the 1135 waiver; -a written communication plan that is reviewed/updated annually and includes: -contact information for Federal, State, tribal, regional and local staff, state licensing agency, MN Office of the Ombudsman for Long-Term Care; and -means to provide information about the facility's occupancy, needs, and its ability to provide assistance; and -documented exercises at least twice per year to test the EP plan including analysis of the facility's response and revision to the plan as needed. On September 24, 2024, at approximately 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated the binder containing the EP plan was kept in a common area with the emergency equipment. LALD/CNS-A stated they were unaware of the Appendix Z requirements and required content of the EP plan. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's EP plan would align with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 800	Continued From page 10	0 800		
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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 September 26, 2024, from 1:30 p.m. to 2:30 p.m. the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. Used cigarette butts were discarded on the ground around the rear deck and onto the surface of the decking. There were appropriate containers provided for discarding the	0 800		

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0 800	Continued From page 11 used cigarette butts outside on the rear brick patio. On September 26, 2024, at 2:30 p.m., LALD/CNS-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 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.	0 810		

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0 810	Continued From page 12 (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 required content and provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 26, 2024, from 1:30 p.m. to 2:30 p.m., the surveyor observed the fire evacuation diagrams did not include accurate identification of room numbers. On September 26, 2024, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36618	A. BUILDING: _____ B. WING _____	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME HEALTH LLC	6426 109TH PLACE NORTH CHAMPLIN, MN 55316

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0 810	Continued From page 13 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. 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 September 26, 2024, at 2:30 p.m. LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work	0 810		

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0 810	Continued From page 14 on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year. The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-A, lacked documentation showing any training was offered or training was scheduled for a future date. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided records were for fire safety training offered by third-party online software that could not be modified to include the facility-specific fire safety plans. LALD/CNS-A was unable to provide documentation showing any training offered or training scheduled for a future date for employees on the fire safety and evacuation plan. On September 26, 2024, at 2:30 p.m. LALD/CNS-A, stated training was conducted at the same time as the fire/evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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	36618	A. BUILDING: _____ B. WING _____	09/27/2024

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01620	Continued From page 15 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 90 days after the previous assessment for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36618	A. BUILDING: _____ B. WING _____	09/27/2024

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01620	Continued From page 16 failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on May 9, 2021, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's record included a Service Plan (Waiver) signed August 9, 2024, indicating R1's services included assistance with dressing and grooming, meal preparation, medication administration, and behavior management. R1's record included 90-day Assessment dated September 21, 2024, and a 90-day assessment dated June 16, 2024, indicating a total of 97 days had passed between assessments. R2 R2 was admitted on March 13, 2021, under the licensee's former comprehensive license and began receiving assisted living services on August 1. 2021. R2's record included a Service Plan (Waiver) signed on August 4, 2024, indicating R2's services included dressing and grooming assistance, meal preparation, medication administration, and behavior management. R2's record included 90-day Assessment dated September 21, 2024, and a 90-day assessment dated June 16, 2024, indicating a total of 97 days had passed between assessments. On September 24, 2024, at approximately 1:24	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 17 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the assessments for R1 and R2 had exceeded the 90-day requirement. LALD/CNS-A stated they were unaware the assessments could be completed prior to 90 days. The licensee's 6.01 Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated 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. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *09/24/24*
Time: 14:00:00
Report: 8087241201

Food and Beverage Establishment Inspection Report

Location:

St Jude Home Health Llc
6426 109th Place North
Champlin, MN55316
Hennepin County, 27

Establishment Info:

ID #: 0037837
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124600018
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: 0 Degrees Fahrenheit - Location: WHIRLPOOL FREEZER
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR II MICHELLE WINTERS.

FLOORS AND COUNTERTOPS ARE LAMINATE, CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE ROUGH IN TEXTURE AND NOT SMOOTH OR EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS.

IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

WHIRLPOOL BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

THERE IS A DESIGNATED HAND WASHING SINK IN THE KITCHEN/DINING ROOM AREA.

INSPECTION REPORT EMAILED TO NURSE EVALUATOR II MICHELLE WINTERS.

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 8087241201 of 09/24/24.

Certified Food Protection Manager: HANNAH Y. ABUMAYALEH

Certification Number: FM124463 Expires: 08/05/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

DOROTHY MINGATE
ASSISTANT DIRECTOR

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us