Electronically Delivered

December 18, 2023

Licensee
Synergycare, LLC
1551 Red Cedar Road
Eagan, MN 55121

RE: Project Number(s) SL37695015

Dear Licensee:

On December 6, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 4, 2023, 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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Electronically Delivered

November 3, 2023

Licensee
Synergycare LLC
1551 Red Cedar Road
Eagan, MN 55121

RE: Project Number(s) SL37695015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 4, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints.

If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

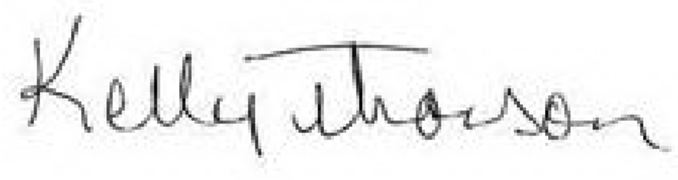
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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

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

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 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
	37695	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYNERGYCARE LLC	1551 RED CEDAR ROAD EAGAN, MN 55121

(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: SL37695015 On October 2, 2023, through October 4, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four active residents; all whom were receiving services under the Assisted Living license. An immediate correction orders were identified on October 3, 2023, issued for SL37695015, tag identification 0820 and 2310. On October 4, 2023, immediacy of correction order 0820 was removed as confirmed by evaluation supervisor, however, non-complaince remains at a scope and level of I. On October 5, 2023, at 4:22 p.m., immediacy of correction order 2310 was removed as confirmed by evaluation supervisor, however,	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 non-compliance remains at a scope and level of H.	0 000		
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide services in a person-centered manner for one of one resident (R1) with behaviors. 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: R1's diagnoses included right spastic hemiplegia,	0 450		

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0 450	Continued From page 2 stroke, type 2 diabetes, seizure disorder, cellulitis of the lower extremities, venous stasis ulcer, sleep apnea, chronic pain disorder, insomnia, personality disorder, hypertension, and bladder spasms. R1's Service Plan dated September 14, 2023, noted services including assistance with bathing, behavior management, compression stockings, dressing, perineal care, and medication administration. On October 3, 2023, at 7:53 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications. R1's incident reports and progress notes included: - April 14, 2023, R1 threw himself out of bed in the early hours of the morning. That afternoon R1 complained of pain in the right wrist, and was sent to the emergency room, where he was diagnosed with a closed fracture; - May 4, 2023, R1 called 911. When police arrived, R1 told them nobody wanted to get him out of bed and into his wheelchair. Staff had not been called by R1 and reminded R1 to call them for getting out of bed, not 911; - May 16, 2023, R1 wanted to throw himself out of bed and he called 911; - May 31, 2023, R1 was yelling out during the night, saying he was anxious. Had called the suicide hotline and told them he wanted to get out of bed. R1 called 911, and when they left continued to yell and threw himself on the floor; - June 2, 2023, resident fell from his bed while sleeping. Staff called 911 and he went to the emergency room for treatment to his forehead; - July 1, 2023, R1 anxious and verbally aggressive, restless and agitated during the night	0 450		

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0 450	Continued From page 3 shift. Requested and received drinks and chips. R1 was assisted to the bathroom and back to bed. R1 threw his lamp on the floor and knocked snacks on the floor; - July 24, 2023, resident verbally abusive because work was being done on the ramp and the door had to remain closed for the cement to dry; - August 13, 2023, R1 yelling and threw his lamp on the floor, threw snacks on the floor, and kicked the side table. Later, R1 threw himself on the floor from his bed; - August 29, 2023, R1 restless, anxious and telling for help. R1 wanted to go to the hospital for complaints something was "coming out of his peri side". Staff checked the area and found nothing. Resident denied pain. Later R1 called 911 and told paramedics his abdomen was hurting, so he was taken to the emergency room; and - August 29, 2023, R1 called 911. He had multiple request to staff during the night. R1 appeared restless, agitated, anxious, and asked to be positioned to the inside of the bed despite being in the middle of the bed. Paramedics arrived to also tell R1 he was in the middle of the bed. On October 4, 2023, at 2:40 p.m., licensed assisted living director (LALD)-B stated he was unable to print out a report of the behaviors and interventions utilized for R1. LALD-B opened the electronic record to show a drop box with approximately 15 interventions that could be utilized. LALD-B and CNS-A stated the same list was available for all residents, and it was not individualized for R1 with specific interventions to use. CNS-A stated R1's psychologist was aware of the behaviors and increased the amount of his visits, but no other new interventions had been	0 450		

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0 450	Continued From page 4 implemented with the behaviors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470		

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0 470	Continued From page 5 by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was developed and posted, potentially affecting the licensee's four current residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee held an assisted living facility license. The facility was licensed for a capacity of five residents and had a current census of four residents. During the entrance conference on October 2, 2023, at 11:00 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated two unlicensed personnel were staffed on each of the three shifts. STAFF POSTING During a tour of the facility with LALD-B and CNS-A on October 2, 2023, at 12:10 p.m., the surveyor observed the facility license posted on the wall above the fireplace at the top of the stairs; however, no posting of the daily staff schedule was observed during the tour. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to:	0 470		

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0 470	Continued From page 6 - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On October 2, 2023, at 1:05 p.m., LALD-B stated the schedule was typically posted on a bulletin board in the small dining area staff utilized for charting. However, it had been removed a couple weeks ago when a resident was pulling postings down and taking the tacks. STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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. On October 3, 2023, at 11:00 a.m., CNS-A provided the staffing plan, which noted "Staffing at SynergyCare is dependent on the needs of the clients that originates from the 6790. In general staffing is 1 staff to 2 clients. We are able to provide one to one services as well." CNS-A stated the plan was undated, and they had	0 470		

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0 470	Continued From page 7 developed the plan after their last survey in 2021 and had not reviewed it since. CNS-A stated they meet frequently to discuss the resident needs and would increase the staffing if needed. However, CNS-A stated they did not have a written plan with the required content. The licensee's Staffing policy dated 2021 noted the staffing plan was based on the evaluation of the appropriateness of the staffing levels in the facility and would be reviewed at least twice a year to include: - the staffing requirements to meet the scheduled and reasonably foreseeable unscheduled needs of the residents based on the assessment and service plan; - the acuity level of the residents based on the nursing assessment; - the facility's ability to respond promptly and effectively to residents; - dementia care requirement; and - the physical layout of the residence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

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0 480	Continued From page 8 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, 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 2, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Refer to comply by dates on the Food and Beverage Establishment Inspection Report	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The	0 485		

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0 485	Continued From page 9 facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all four residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's contract lacked an option for residents to opt out of payment for meals residents would not want. During the entrance conference on October 2, 2023, at 11:00 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided three meals per day to the residents.	0 485		

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0 485	Continued From page 10 The licensee's Rental Agreement noted the monthly rent included three meals per day, plus snacks. On October 4, 2023, at 1:20 p.m., LALD-B stated all meals were included in the cost of rent, and residents had not asked to only receive certain meals. LALD-B stated residents were not given the option to select other than all meals. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of two	0 510		

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	37695	A. BUILDING: _____ B. WING _____	10/04/2023

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0 510	Continued From page 11 employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 3, 2023, at 7:53 a.m., the surveyor observed ULP-C administer insulin to R1 in his room. With gloved hands, ULP-C wiped the lower right abdomen with an alcohol wipe, administered the insulin, exited R1's room, placed the needle in the sharps container on the wall outside the resident's room, removed her gloves, opened the medication closet with her keys, placed the medication box in the drawer, closed the door, went upstairs, and at this point utilized hand sanitizer. On October 3, 2023, at 8:20 a.m., ULP-C stated she was nervous and did not do hand hygiene but should have after disposing of the sharps and removing her gloves. On October 3, 2023, at 8:25 a.m., clinical nurse supervisor (CNS)-A stated she expects hand hygiene to be done after removing the gloves. The licensee's Infection Control policy dated August 1, 2021, noted hands were to be washed if contaminated with blood or body fluid, immediately after gloves were removed, between resident contact, and when indicated to prevent	0 510		

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0 510	Continued From page 12 the transfer of microorganisms between resident or the environment. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.1-2 reads: 1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 550		

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0 550	Continued From page 13 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 post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's four 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, 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: The licensee lacked a posting of the grievance procedure to include the name, telephone number and e-mail contact information for the individuals responsible for handling resident grievances. During a tour of the facility with licensed assisted	0 550		

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0 550	Continued From page 14 living director (LALD)-B and clinical nurse supervisor (CNS)-A on October 2, 2023, at 12:10 p.m., the surveyor observed the facility license posted on the wall above the fireplace at the top of the stairs; however, no posting of the grievance procedure was noted. On October 2, 2023, at 1:05 p.m., LALD-B stated the grievance procedure was typically posted on a bulletin board in the small dining area staff utilized for charting. However, it had been removed a couple weeks ago when a resident was pulling postings down and taking the tacks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse	0 630		

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0 630	Continued From page 15 prevention plan (IAPP) was developed to include 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 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's diagnoses included right spastic hemiplegia, stroke, type 2 diabetes, seizure disorder, cellulitis of the lower extremities, venous stasis ulcer, sleep apnea, chronic pain disorder, insomnia, personality disorder, hypertension, and bladder spasms. R1's incident reports noted the following: - April 14, 2023, R1 threw himself out of bed in the early hours of the morning. In the afternoon R1 complained of pain in the right wrist, and was sent to the emergency room, where he was diagnosed with a closed fracture; - May 16, 2023, R1 wanted to throw himself out of bed; - May 31, 2023, R1 was yelling out during the night, saying he was anxious. R1 had called the suicide hotline and told them he wanted to get out of bed. R1 called 911, and when they left continued to yell and threw himself on the floor; - June 2, 2023, resident fell from his bed while sleeping. Staff called 911 and he went to the emergency room for treatment to his forehead; and - August 13, 2023, R1 threw himself on the floor	0 630		

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0 630	Continued From page 16 from his bed. R1's Individual Abuse Prevention Plan dated August 31, 2023, failed to include: - the person's susceptibility to abuse including self-abuse; - specific measures to minimize the risk of abuse including self-abuse. R1's Service Plan dated September 14, 2023, noted services including assistance with bathing, behavior management, compression stockings, dressing, perineal care, and medication administration. On October 4, 2023, at 2:40 p.m., clinical nurse supervisor (CNS)-A stated the IAPP for R1 did not include the vulnerability of self-abuse or specific measure to minimize the risk of abuse. The licensee's Vulnerable Adult policy dated August 1, 2021, noted the licensee would assess the vulnerability status of each resident, and noted susceptibility to abuse included self-abuse. It also noted the assessment should include statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for	0 640		

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0 640	Continued From page 17 reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and the 911 emergency number in common areas and near telephones provided by the facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a tour of the facility with licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A on October 2, 2023, at 12:10 p.m., the surveyor observed the facility license posted on the wall above the fireplace at the top	0 640		

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0 640	Continued From page 18 of the stairs; however, none of the required MAARC contact information or 911 emergency number was posted. On October 2, 2023, at 1:05 p.m., LALD-B stated the grievance procedure was typically posted on a bulletin board in the small dining area staff utilized for charting. However, it had been removed a couple weeks ago when a resident was pulling postings down and taking the tacks. The licensee's undated Vulnerable Adult policy noted contact information for MAARC would be posted in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

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0 650	Continued From page 19 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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-C had a hire date of July 27, 2023. On October 3, 2023, at 7:45 a.m., the surveyor observed ULP-C administer medications to R1 in his room. ULP-C's employee record lacked evidence of orientation to include: - overview of Assisted Living statutes; - review of provider's policies and procedures; - reporting maltreatment of vulnerable adults; - handling of resident complaints, reporting of	0 650		

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0 650	Continued From page 20 complaints, where to report; - review of the types of Assisted Living services the employee would provide and the provider's scope of license; and - principles of person-centered planning and service delivery. On October 4, 2023, at 2:30 p.m., licensed assisted living director (LALD)-B stated there was an orientation checklist he goes through with all employees on hire. LALD-B added he had provided this training to ULP-C, but the record lacked the documentation. The licensee's Staff Orientation and Education policy dated August 1, 2021, noted an orientation checklist would be used to document and verify the completion of orientation for each employee, and upon completion, the signed and dated checklist would be retained in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 21 (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 observation, interview, and record review the licensee failed to have a written emergency preparedness plan (EPP) with all of the required content defined in Appendix Z and failed to post an emergency preparedness plan prominently. In addition, the licensee lacked a missing resident plan with the required content and failed to evaluate/revise its plan at least quarterly. This had the potential to affect all four residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 22 The findings include: During the initial tour with licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A on October 2, 2023, at 12:10 p.m., the facility's layout included a split entry main entrance. The upper level included two resident rooms, the kitchen and dining room (utilized for staff charting), the living room and dining area for residents and a bathroom. The lower level included three resident rooms, a common area, a laundry/utility room, a bathroom, and two closets for medication storage. There was no evidence of signage posted or information regarding the licensee's emergency plan. Upon completion of the tour the surveyor asked for the location of the EPP, LALD-B stated it was always stored in the cupboard in the kitchen/dining area, but it was not there at this time. LALD-B stated at times this cupboard was locked because medications were stored in there before being administered to the residents at meal times. LALD-B stated he would locate the binder and provide it. On October 3, 2023, at 8:00 a.m., the EPP binder dated November 21, 2022, was provided for the surveyor. The EPP lacked the following required content: - documentation of a missing resident plan that is reviewed quarterly; - development of policies/procedures to address whether evacuated or shelter in place for staff/residents: - food, medical supplies, pharmaceutical supplies; - alternative sources of energy to maintain: - temperatures to protect resident health/safety; and - safe/sanitary storage of provisions.	0 680		

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0 680	Continued From page 23 - develop policies/procedures to address: - systems of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy/procedure to address the use of volunteers, including the process/role for integration; - policy/procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - a communication plan that included: - a method of sharing information and medical documentation for residents; - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - method of sharing information from the emergency plan, that the facility had determined appropriate, with residents and their families/representatives. - EP training and testing program; and - EP testing/annual testing requirements. On October 4, 2023, at 12:25 p.m., LALD-B and CNS-A stated the EPP lacked the above required content. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified	0 680		

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0 680	Continued From page 24 Supplier Types: Interpretive Guidance," which is incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide current tags and documentation of annual and monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents.	0 790		

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	37695	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYNERGYCARE LLC	1551 RED CEDAR ROAD EAGAN, MN 55121

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0 790	Continued From page 25 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). Findings include: On a facility tour on October 3, 2023, at approximately 12:58 p.m. to 1:30 p.m., with Licensed Assisted Living Director (LALD)-B, survey staff observed that the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that annual and monthly inspections had been performed as required. The annual inspection tag was from November 2022 and monthly documentation had not been done. Annual and monthly inspections of the fire extingushers are required by NFPA standards and Minnesota State Fire Code to ensure that all systems are maintained and remain in working order. LALD-B verbally confirmed survey staff observations. No further information 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	0 800		

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0 800	Continued From page 26 (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 path of egress in a manner that allowed the facility to be accessible to fire department services and emergency medical services. This had the potential to directly affect all of the 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 of the residents). The findings include: On October 3, 2023, from approximately 12:58 p.m. to 1:45 p.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-B. During the facility tour, survey staff observed that an exit sign was posted above the basement exit door. This exit door leads out into a fenced in patio which makes the only way to exit is through the garage. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the	0 800		

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0 800	Continued From page 27 garage. This exit door was included in the fire safety evacuation plan. LALD-B verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide properly sized egress windows for resident rooms that did not create a distinct hazard for residents. This had the potential to directly affect a portion of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 820	This immediate correction order identified on October 3, 2023, has had the immediacy lifted as of October 4, 2022 by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 28 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 portion or all of the residents). The findings include: On October 03, 2023, between the hours of 2:10 p.m. and 2:38 p.m., survey staff conducted a facility tour with Licensed Assisted Living Director (LALD-B). During facility tour, survey staff observed the following: LALD-B fully opened the proposed egress window in occupied resident room #1 and survey staff verified the measurement of the openable area of the window to be 40.5" high x 17.75" wide for a total of 719 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". LALD-B visually verified the deficient condition. LALD-B fully opened the proposed egress window in unoccupied resident room #3 and survey staff verified the measurement of the openable area of the window to be 32" high x 18.25" wide for a total of 584 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". LALD-B visually verified the deficient condition.	0 820		

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0 820	Continued From page 29 Occupied resident room # 4 has a patio door for egress. The patio door leads into a fenced in patio area which the only option to exit is to go through the garage. LALD-B visually verified the deficient condition. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets.	0 920		

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0 920	Continued From page 30 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for one of one resident (R1). This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include: - a delineation of the cost and nature of any other services to be provided for the contracted amount; and - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract. R1's diagnoses included right spastic hemiplegia, stroke, type 2 diabetes, seizure disorder, cellulitis of the lower extremities, venous stasis ulcer, sleep apnea, chronic pain disorder, insomnia, personality disorder, hypertension, and bladder spasms. R1's Service Plan dated September 14, 2023, noted services including assistance with bathing, behavior management, compression stockings, dressing, perineal care, and medication	0 920		

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0 920	Continued From page 31 administration. R1's Assisted Living Contract dated June 3, 2023, lacked the above required content. On October 4, 2023, at 1:15 p.m., clinical nurse supervisor (CNS)-A stated R1's contract did not include the required content and said the same contract format was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060		

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01060	Continued From page 32 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R1) hospitalized. 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:	01060		

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01060	Continued From page 33 R1's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. R1's diagnoses included right spastic hemiplegia, stroke, type 2 diabetes, seizure disorder, cellulitis of the lower extremities, venous stasis ulcer, sleep apnea, chronic pain disorder, insomnia, personality disorder, hypertension, and bladder spasms. R1's Service Plan dated September 14, 2023, noted services including assistance with bathing, behavior management, compression stockings, dressing, perineal care, and medication administration. On October 3, 2023, at 7:53 a.m., the surveyor observed ULP-C administer R1's scheduled morning medications. R1's incident report dated May 19, 2023, noted R1 was sent to the emergency room for	01060		

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01060	Continued From page 34 evaluation, and was admitted to the hospital. On October 4, 2023, at 2:40 p.m., clinical nurse supervisor (CNS)-A stated R1 returned to the facility on May 20, 2023, and said she was not aware of the requirement to provide this information to the resident, legal representative, and designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
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 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	01500		

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01500	Continued From page 35 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: (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 interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (licensed assisted living director (LALD)-B).	01500		

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01500	Continued From page 36 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: LALD-B had a hire date of March 7, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2023. LALD-B's employee record lacked evidence the employee had successfully completed annual training as required, to include: - review of the provider's policies and procedures; and - principles of person-centered planning and service delivery. On October 4, 2023, at 2:20 p.m., LALD-B stated he had missed doing the above required annual training. The licensee's Staff Orientation and Education policy dated August 1, 2023, noted all staff providing assisted living services would complete at least eight hours of education for every twelve months of employee to include a review of the licensee's policies and procedures related to the providing of assisted living services and how to implement them and the principles of person-centered planning and service delivery and how they apply to direct support services	01500		

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01500	Continued From page 37 provided by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01620		

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01620	Continued From page 38 registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 90 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 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: R1's diagnoses included right spastic hemiplegia, stroke, type 2 diabetes, seizure disorder, cellulitis of the lower extremities, venous stasis ulcer, sleep apnea, chronic pain disorder, insomnia, personality disorder, hypertension, and bladder spasms. R1's Service Plan dated September 14, 2023, noted services including assistance with bathing, behavior management, compression stockings, dressing, perineal care, and medication administration. On October 3, 2023, at 7:53 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications. R1's Assessment by Date dated August 31, 2023, identified as a post emergency room visit, included all areas of the uniform assessment tool. R1's Comprehensive Physical Assessment dated September 11, 2023, identified as a 90 day assessment, included a review of R1's vital signs,	01620		

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	37695	A. BUILDING: _____ B. WING _____	10/04/2023

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01620	Continued From page 39 diagnoses, safety hazards, eyes, ears, nose, throat, mouth, pain, skin, cardiac assessment, respiratory status, genitourinary system, gastrointestinal/nutritional status, endocrine system, psychosocial assessment, neurological/behavioral/mental status, musculoskeletal assessment, appliances/equipment, falls risk, and vulnerabilities. The assessment did not include all the elements of the universal assessment tool. On October 4, 2023, at 2:40 p.m., clinical nurse supervisor (CNS)-A stated the Assessment by Date was utilized by her for focused assessments only, and she did not review all portions included for each focused survey. CNS-A also stated the comprehensive physical assessment was what she used for the 90 day reassessments, and said it did not include all required areas of the uniform assessment tool. CNS-A stated this was how she completed the assessments for all residents. Minnesota Rules - Assisted Living Facilities 4659.0150 Uniform Assessment Tool, subdivision 2 indicated each facility must develop a uniform assessment tool. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. The licensee's Comprehensive Nursing Assessment dated August 1, 2021, noted the RN would conduct a comprehensive assessment for all residents to address the resident's physical, mental and cognitive needs. No further information was provided. TIME PERIOD FOR CORRECTION:	01620		

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01620	Continued From page 40 Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan included the required content for one of one	01650		

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01650	Continued From page 41 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included right spastic hemiplegia, stroke, type 2 diabetes, seizure disorder, cellulitis of the lower extremities, venous stasis ulcer, sleep apnea, chronic pain disorder, insomnia, personality disorder, hypertension, and bladder spasms. R1's Service Plan dated September 14, 2023, noted services including assistance with bathing, behavior management, compression stockings, dressing, perineal care, and medication administration. The service plan lacked: - the fees for services. On October 3, 2023, at 7:53 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications. On October 4, 2023, at 2:40 p.m., clinical nurse supervisor (CNS)-A stated the four current residents received payment through a waiver. CNS-A stated their service plans did not indicate the fees for services or that the service was paid by a waiver. The licensee's Service Plan policy dated August	01650		

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01650	Continued From page 42 1, 2021, noted the service plan would include a description of the services to be provided, the fees for services, and the frequency of each service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
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 medications were administered per manufacturer instructions 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	01760		

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01760	Continued From page 43 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: R1's diagnoses included right spastic hemiplegia, stroke, type 2 diabetes, seizure disorder, cellulitis of the lower extremities, venous stasis ulcer, sleep apnea, chronic pain disorder, insomnia, personality disorder, hypertension, and bladder spasms. R1's Service Plan dated September 14, 2023, noted services including assistance with bathing, behavior management, compression stockings, dressing, perineal care, and medication administration. R1's prescriber orders dated July 6, 2023, included Lantus Solostar inject 45 units subcutaneously (SQ) twice daily and Novolog Flexpen inject 7 units SQ three times daily plus sliding scale. On October 3, 2023, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-C wipe the top of the Lantus Solostar with an alcohol wipe, attach a needle, and dialed the pen to 45 units. Next ULP-C wiped the top of the Novolog Flexpen with an alcohol wipe, attach a needle, and dialed the pen to 7 units. ULP-C stated R1's blood glucose reading was 133 milligrams (mg)/deciliter (dL), and did not require any sliding scale amount for this result. At 7:53 a.m., the surveyor observed ULP-C enter the resident's room, wiped the abdomen with an alcohol wipe, and administered the insulin in two locations.	01760		

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01760	Continued From page 44 On October 3, 2023, at 8:20 a.m., ULP-C stated she had not been trained to prime the insulin pen prior to drawing up the prescribed amount. Licensed assisted living director (LALD)-B said clinical nurse supervisor (CNS)-A had trained them to prime the pen, but ULP-C must have been nervous and forgotten. On October 3, 2023, at 8:25 a.m., CNS-A stated she trained staff and expects them to prime the insulin pens by dialing them to 2 units and expressing the liquid prior to drawing up the prescribed amount. The manufacturer's instructions for use of the Lantus Solostar pen dated 2022 instructed to dial a test dose of 2 units, lightly tap the insulin reservoir so air bubbles rise to the top of the needed to help get the most accurate dose, and press the button all the way in and be sure insulin comes out of the needle, and then dial to the required dose. The manufacturer's instructions for use of the Novolog Flexpen dated February 2023 instructed to turn the dose selector to select 2 units, tap the cartridge gently to make any air bubbles collect at the top of the cartridge and press the push-button when a drop of insulin should appear at the needle tip. At this point, turn the dose selector to the number of units to be injected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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02310	Continued From page 45	02310		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) whose hospital bedrails were removed without an assessment by the registered nurse (RN) and failed to ensure one of one resident (R2) utilizing a consumer bed rail was assessed. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: This resulted in an immediate correction order on October 3, 2023, at 1:44 p.m. HOSPITAL RAILS REMOVED R1's diagnoses included right spastic hemiplegia, stroke, type 2 diabetes, seizure disorder, cellulitis	02310		

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02310	Continued From page 46 of the lower extremities, venous stasis ulcer, sleep apnea, chronic pain disorder, insomnia, personality disorder, hypertension, and bladder spasms. R1's Service Plan dated September 14, 2023, noted services including assistance with bathing, behavior management, compression stockings, dressing, perineal care, and medication administration. R1's Assessment by Date dated August 31, 2023, identified as a post emergency room visit, noted R1 utilized a grab bar with the left hand and needed help to sit up in bed, and utilized the bed rail to aid in positioning. It noted R1 was wheelchair bound and required two persons to assist with transfers. The assessment noted R1 had difficulty sleeping and got up in the middle of the night, and bilateral edema to the feet/ankles. It noted under bed safety R1 had a hospital bed with mattress original to bed, with a partial side rail, and added R1 utilized right side rail only, and did not prefer the left side rail, the rail was utilized to aid in turning and repositioning. It noted R1 utilized a hanging triangle bar for positioning also. It noted education had been provided and the risks of the rails and been provided. Under the section "bed rail meets FDA guidelines," no note was made, and no measurements were documented. R1's record contained a copy of A Guide to Bed Safety. R1's Comprehensive Physical Assessment dated September 11, 2023, identified as the 90-day assessment, lacked information on the bed rail. R1's Incident report dated April 14, 2023, at 2:00 p.m., noted R1 threw himself out of the bed during the night without calling staff for help. R1	02310		

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02310	Continued From page 47 complained of wrist pain and went to the emergency room for evaluation and found to have a closed fracture of the right arm. R1's Incident report dated June 2, 2023, at 2:55 a.m., noted R1 fell out of his bed while sleeping. Staff heard a loud noise and screaming and found R1 on the floor with blood all over him. Staff called 911 and R1 was taken to the emergency room for evaluation. No injury was noted from imaging. R1 received treatment to the mid forehead and returned to the facility. On October 3, 2023, at 8:48 a.m., clinical nurse supervisor (CNS)-A stated there were no measurements taken for R1's bed rails. The surveyor and CNS-A went into R1's room with his permission to look at his bed and found no bed rail was on either side of the hospital bed. CNS-A stated she did not know who had removed them or when they were removed. CNS-A stated the assessment she completed did not include information on the bed rails, and noted the assessment dated August 31, 2023, was a focused assessment and she had not looked at the bed rails. CNS-A stated she did not reassess R1 after the bed rails had been removed, and there was not anything documented in R1's record indicating he was not utilizing the bed rails. On October 3, 2023, at 8:56 a.m., licensed assisted living director (LALD)-B stated one of the day staff had removed the bed rails from R1's bed "a few months ago." R1's record lacked evidence the facility assessed R1 for safety prior to the removal of the assistive device. CONSUMER RAILS	02310		

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02310	Continued From page 48 On October 3, 2023, at 8:14 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration to R2 in her room. R2's room was observed to have a queen-sized bed with a consumer rail on the left side of the bed. R2 stated she had this because she used to fall out of bed, so this helps her to know when she is getting too close to the edge of the bed, and she moves over. R2 stated she also uses it to help scoot herself down towards the end of the bed to get out. On October 3, 2023, at 8:25 a.m., CNS-A stated R2 just got the consumer rail on the bed. They had gotten an order from the prescriber and sent it to the medical supply company. CNS-A stated she did not do an assessment on the consumer rail, and added she did not think it was applicable because it was not a hospital bed. CNS-A provided the manufacturer guidelines for installation and stated she had not checked the Consumer Product Safety Commission (CPSC) to see if the device had been recalled. On October 3, 2023, at 10:20 a.m., the surveyor observed R2's bed with LALD-B and CNS-A. R2 was in her room and gave permission to look at the bed again. R2's bed was observed as a queen bed with the right side pushed against the wall. The bed had no headboard or footboard. The left side of the bed had a black metal rectangular shaped rail with 4 horizontal bars. The right and left side of the rails curved to be placed between the mattress and box spring. A strap went from the inner most portion of the rails, approximately 1/3 of the way under the mattress where they joined, wrapped around the box spring, and came back to the left side where it was clasped together with a plastic buckle.	02310		

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02310	Continued From page 49 The Stander 30-inch Safety Bed Rail product information dated June 22, 2021, noted the product was not intended for use by individuals who have sleeping disorders. R2's diagnoses included anxiety, sleep apnea, major depressive disorder, narcolepsy, hypertension, and chronic pain. R2's Service Plan signed by R2 and the licensee on July 20, 2023, noted services including assistance with bathing, behavior management, dressing, housekeeping, exercise, and medication administration. R2's Assessment by Date dated August 5, 2023, noted R2 was independent with bed mobility, and made no mention of a consumer rail. It noted R2 at times required assistance of one person to transfer and walking. It noted R2 utilized a wheelchair or scooter at times and a walker at times. The assessment noted R2 utilized a CPAP while sleeping, at times had difficulty sleeping and would nap at times. Under bed safety it noted a queen-sized mattress, original to the bed, and no assistive device was needed for the bed. It also noted at times R2 was disoriented to time and forgetful. R2's record lacked evidence the licensee had completed an individualized bed rail assessment, provided education on the risk versus benefits of the consumer rail use, referred to the CPSC to check for recall information, and lacked information on whether the device was being utilized as a restraint. The licensee's Side Rail Use policy dated 2021, noted before implementing side rails (bed rails) for a resident, the RN would conduct an	02310		

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02310	Continued From page 50 assessment to include the level of mobility, level of consciousness, level of cognition, presence of orthostatic hypotension, and vision. It noted the RN would discuss alternatives to the use of the bed rails, provide education related to the use of the rails, and document the purpose of the rails and education provided. It also noted the need for the bed rails would be reassessed and documented as needed, but not less than every 90 days. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked-Questions (FAQs) dated August 7, 2023, indicated the licensee should ensure that an assessment was completed, the bed rails were determined to not act as a restraint, and the risk versus benefits were discussed and documented with the resident/responsible party. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed on October 5, 2023, at 4:22 p.m., as confirmed by evaluation supervisor, however, non-compliance remains at a scope and level of H.	02310		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with	02320		

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02320	Continued From page 51 continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for medication set up by two of two employees (licensed assisted living director (LALD)-B and unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-B had a hire date of March 7, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2023. ULP-C had a hire date of July 27, 2023, to provide assisted living services. During the initial tour on October 2, 2023, at 12:10 p.m., the surveyor observed the area next to the kitchen utilized for staff charting with a cupboard for binders. LALD-B stated medications were currently in medication cups and placed in	02320		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYNERGYCARE LLC	1551 RED CEDAR ROAD EAGAN, MN 55121

(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
02320	Continued From page 52 this cabinet for all three residents in the building today, to be administered when they get their lunch. LALD-B stated ULP-C did the first check and made a check mark on the package. LALD-B then did the second check and marked the verified box in the electronic medication administration record. ULP-C then punched the medications from the package into a medication cup, setup the insulin if needed, and placed pre set-up medications in plastic square boxes in the cupboard until residents came for their meals. Clinical nurse supervisor (CNS)-A stated she was aware staff were setting up medications in this manner. She added that staff were doing the double checks like this to prevent medication errors, and that she was not aware medications could not be setup for later administration in this manner. According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *10/02/23*
Time: 12:00:00
Report: 1005231228

Food and Beverage Establishment Inspection Report

Location:
Synergycare Llc
1551 Red Cedar Road
Eagan, MN55121
Dakota County, 19

Establishment Info:
ID #: 0037871
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128051118
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

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

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

TCS FOODS IN THE DRAWER NEAR THE BOTTOM OF THE REFRIGERATOR WERE ABOVE 41 DEGREES F. MOVE TCS FOODS, SUCH AS MEATS AND CHEESES TO ONE OF THE HIGHER SHELVES, WHERE IT IS COLDER. SEE COMMENTS.

Comply By: 10/02/23

4-300 Equipment Numbers and Capacities

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

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

NO DEVICE ON SITE. DISCUSSED REQUIREMENT TO PROVIDE A MAXIMUM REGISTERING THERMOMETER OR TEMPERATURE SENSITIVE STRIPS TO ENSURE THE DISHWASHER IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE.

Comply By: 10/09/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

NO SIGN POSTED AT SINK. SIGN LEFT ON SITE.

Comply By: 10/02/23

Type: Full
Date: *10/02/23*
Time: 12:00:00
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Synergycare Llc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 33 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR - TOP SHELF
Violation Issued: No

Process/Item: Cold Hold/BUTTER
Temperature: 41 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR - MIDDLE SHELF
Violation Issued: No

Process/Item: Cold Hold/HOT DOG
Temperature: 48 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR - DRAWER
Violation Issued: Yes

Process/Item: Cold Hold/CHEESE
Temperature: 48 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR - DRAWER
Violation Issued: Yes

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

INSPECTION COMPLETED WITH FOOD MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR ANNETTE TRUEBACK.

THE REFRIGERATOR WAS ALREADY ON THE COLDEST SETTING, BUT WAS NOT KEEPING TCS FOODS IN THE DRAWERS COLD ENOUGH. REORGANIZE FOODS SO NON-TCS ITEMS (SUCH AS BREAD AND PRODUCE) ARE STORED IN THE DRAWERS AND TCS FOODS (SUCH AS DELI MEAT AND CHEESES) ARE STORED ON THE SHELVES WHERE THE TEMPERATURE IS 41 DEGREES F AND BELOW.

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

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND THE CEILING HAS A POPCORN FINISH. 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.

Type: Full
Date: *10/02/23*
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Report: 1005231228
Synergycare Llc

Food and Beverage Establishment Inspection Report

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 1005231228 of 10/02/23.

Certified Food Protection Manager: JENNA S. NNAJI

Certification Number: FM108604 Expires: 08/30/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
JENNA NNAJI
SUPERVISOR

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