



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 1, 2023

Licensee
Caring Friends, LLC
2000 Raymar Court
Burnsville, MN 55337

RE: Project Number(s) SL36255015

Dear Licensee:

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

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

An equal opportunity employer.

Letter ID: IS7N REVISED

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

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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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: SL36255015 On October 2, 2023, through October 3, 2023, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three active residents; three receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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
0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was evaluated for appropriateness of staffing levels as required, potentially affecting all of the current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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
0 470	Continued From page 2 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 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. The licensee held an assisted living license and was licensed for a bed capacity of four residents. The [licensee name] Staffing Plan dated October 3, 2023, indicated one unlicensed personnel (ULP) from 8:00 a.m. to 4:00 p.m., one ULP from 4:00 p.m. to 10:00 p.m., and one ULP from 10:00 p.m. to 8:00 a.m., and indicated the staffing plan would be reviewed at least twice a year, and would be updated as needed. The staffing plan identified the adequate number of staff was determined by an assessment by a registered nurse (RN). On October 3, 2023, at 1:47 p.m. licensed assisted living director (LALD)-A stated the staff plan was last reviewed on January 3, 2022, and the staffing plan was not reviewed at least twice a year. The licensee's Staffing policy, undated, indicated the staffing plan would be evaluated for the appropriateness of staffing levels in the facility and revised as needed at a minimum of two times per year. No further information was provided.	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337			
(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
0 470	Continued From page 3	0 470			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 2, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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
0 630	Continued From page 4 (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 observation, interview, and record review, the licensee failed to develop an individual abuse prevention plan with all 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 began receiving assisted living services on May 13, 2022. R1's service plan dated October 2, 2023, indicated R1 received assistance with bathing, grooming, dressing, and medication administration.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337			
(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
0 630	Continued From page 5 On October 3, 2023, at 12:00 p.m. licensed assisted living director (LALD)-A was observed to administer R1's morning medications. R1's Individual Abuse and Prevention Plan dated August 10, 2023, lacked: -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. On October 3, 2023, at 11:12 a.m. LALD-A stated R1's individualized abuse and prevention plan dated August 10, 2023, lacked the above required content. The licensee's Individual Abuse and Prevention Plan policy dated August 1, 2021, indicated the individual abuse and prevention plan would include: -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 -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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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
0 660	Continued From page 6	0 660			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included an updated facility TB risk assessment. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337			
(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
0 660	Continued From page 7 The findings include: The licensee's TB facility risk assessment, undated, noted a low risk. The licensee's Facility TB Risk Assessment Worksheet noted their TB risk assessment would be conducted or updated annually/as needed. On October 2, 2023, at 1:54 p.m. licensed assisted living director (LALD)-A stated the licensee had not completed their annual TB facility risk assessment as indicated in their policy. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The licensee's TB Prevention and Control policy dated August 1, 2023, indicated annual review and revision as needed of the TB risk assessment for the facility based on the risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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
0 780	Continued From page 8 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed smoke alarms that were interconnected so that the actuation of one alarm causes all alarms to operate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337			
(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
0 780	Continued From page 9 Findings include: On a facility tour on October 2, 2023, at approximately 11:20 a.m., with Licensed Assisted Living Director (LALD)-A it was observed that the smoke alarms were not interconnected so that the operation of one alarm caused all alarms to operate when tested by the facility staff. LALD/RN-A visually verified this deficient condition at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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
0 800	Continued From page 10 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 2, 2023, at approximately 3:00 p.m. with Licensed Assisted Living Director (LALD)-A it was observed that the smoke alarm in sleeping room #1 had the battery removed. LALD-A visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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
01730	Continued From page 11 relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337			
(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
01730	Continued From page 12 situation has occurred only occasionally). The findings include: R1 began receiving assisted living services on May 13, 2022. R1's service plan dated October 2, 2023, indicated R1 received assistance with medication administration. On October 3, 2023, at 12:00 p.m. licensed assisted living director (LALD)-A was observed to administer R1's morning medications. R1's record lacked a medication management plan to include the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337			
(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
01730	Continued From page 13 On October 3, 2022, at 2:13 p.m. LALD-A stated R1's medication management plan lacked the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure nursing staff administered prescribed medication per manufacturer's instruction for one of two residents (R3). 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	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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
01750	Continued From page 14 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: R3's diagnoses included bipolar disorder. R3's service plan dated August 1, 2023, indicated R3 received assistance with medication administration. R3's physician orders dated September 13, 2023, included fluticasone-salmeterol (steroid and bronchodilator used to prevent asthma symptoms) 100-50 micrograms (mcg), inhale 1 puff into lungs every 12 hours. R3's medication administration record (MAR) dated October 2023, included fluticasone-salmeterol 100-50 mcg, inhale 1 puff into lungs every 12 hours. On October 3, 2023, at 10:16 a.m. licensed assisted living director (LALD)-A was observed setting up R3's morning medications for administration. LALD-A retrieved fluticasone-salmeterol inhaler from the medication cart and compared medication to electronic medication administration record (EMAR) and administered one puff to R3. On October 3, 2023, at 10:20 a.m. the surveyor asked LALD-A if the manufacturer instruction was followed for fluticasone-salmeterol, and LALD-A stated she should have had R3 rinse his mouth out after it was administered. The manufacturer's instructions for	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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
01750	Continued From page 15 fluticasone-salmeterol inhaler dated January 2019, indicated after inhalation, the patient should rinse the mouth with water and spit out without swallowing. The licensee's Delegation of Nursing Task policy dated August 1, 2021, indicated a registered nurse (RN) may delegate medication administration to unlicensed personnel (ULP) after the RN has instructed the ULP in the proper methods to administer the medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure time sensitive medications were dated when opened for two of two residents (R3, 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	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337			
(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
01890	Continued From page 16 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 10:20 a.m. the surveyor observed the medication cart with licensed assisted living director (LALD)-A. R3's in use fluticasone-salmeterol 100-50 micrograms (mcg) (steroid and bronchodilator) lacked a date the inhaler had been removed from the foil packaging pouch and when the inhaler would expire. R1's in use atropine sulfate 1% (for excessive salivation) lacked a date the drops had been open and when the drops would expire. LALD-A confirmed the findings and stated she was not aware the respective inhaler and drops should be dated when opened and when they would expire. On October 3, 2023, at 2:13 p.m. clinical nurse supervisor (CNS)-B stated all time sensitive should be dated when opened. The manufacturer's instructions for fluticasone-salmeterol dated August 2020, directed to discard the inhaler one month after opening the foil pouch. The atropine sulfate 1% package leaflet information for the user revised June 29, 2020, directed to discard the bottle 28 days after opening, even if there is solution remaining. The licensee's Storage of Medication policy, undated, noted the medication must include the	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER CARING FRIENDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RAYMAR COURT BURNSVILLE, MN 55337		
(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	
01890	Continued From page 17 expiration date of time-dated drugs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Type: Full
Date: 10/02/23
Time: 12:44:40
Report: 1036231258

Food and Beverage Establishment Inspection Report

Page 1

Location:

Caring Friends Llc
2000 Raymar Court
Burnsville, MN55337
Dakota County, 19

Establishment Info:

ID #: 0038111
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127232281
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.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. EXAMPLE MDH ILLNESS LOG EMAILED TO ESTABLISHMENT.

Comply By: 10/03/23

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

3-302.11A(1)

**** Priority 1 ****

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

OBSERVED EGGS STORED OVER RTE FOOD IN THE FRIDGE. ISSUE CORRECTED ON SITE.

Comply By: 10/02/23

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.

OBSERVED SEVERAL TCS FOODS IN THE FRIDGE OVER 41DF. ITEMS DISCARDED ON SITE. INSTRUCTED TO TURN DOWN TEMPERATURE OF FRIDGE AND MONITOR TEMPERATURE.

Comply By: 10/03/23

Type: Full
Date: 10/02/23
Time: 12:44:40
Report: 1036231258
Caring Friends Llc

Food and Beverage Establishment Inspection Report

Page 2

3-500C Microbial Control: date marking

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

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

OBSERVED SEVERAL OPENED CONTAINERS/PACKAGES OF TCS FOOD WITH NO DATE LABEL IN THE FRIDGE. DEVELOP A CONSISTENT DATE MARKING METHOD AND MAINTAIN.

Comply By: 10/03/23

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER WAS READILY AVAILABLE. PROVIDE AND MAINTAIN.

Comply By: 10/03/23

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED FOOD DEBRIS/GREASE INSIDE THE AIR FRYER. CLEAN AT A GREATER FREQUENCY TO PREVENT SUCH ACCUMULATION OF RESIDUE.

Comply By: 10/03/23

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 170 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp

Temperature: 1 Degrees Fahrenheit - Location: CHEST FREEZER

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 0 Degrees Fahrenheit - Location: FRIGIDAIRE FREEZER

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 48 Degrees Fahrenheit - Location: FRIGIDAIRE FRIDGE

Violation Issued: Yes

Process/Item: Cold Hold/MILK

Temperature: 46 Degrees Fahrenheit - Location: FRIGIDAIRE FRIDGE

Violation Issued: Yes

Type: Full
Date: 10/02/23
Time: 12:44:40
Report: 1036231258
Caring Friends Llc

Food and Beverage Establishment Inspection Report

Page 3

Process/Item: Cold Hold/SPINACH DIP
Temperature: 47 Degrees Fahrenheit - Location: FRIGIDAIRE FRIDGE
Violation Issued: Yes

Process/Item: Cold Hold/CREAM CHEESE
Temperature: 47 Degrees Fahrenheit - Location: FRIGIDAIRE FRIDGE
Violation Issued: Yes

Process/Item: Cold Hold/YOGURT
Temperature: 47 Degrees Fahrenheit - Location: FRIGIDAIRE FRIDGE
Violation Issued: Yes

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS JENN PANITZKE. INSPECTION CONDUCTED IN PRESENCE OF HALIMO ADAN THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

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

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- DATE MARKING.
- PROPER FOOD STORAGE.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

****IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.**

Type: Full
Date: 10/02/23
Time: 12:44:40
Report: 1036231258
Caring Friends Llc

Food and Beverage Establishment Inspection Report

Page 4

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1036231258 of 10/02/23.

Certified Food Protection Manager Muna A. Hussein

Certification Number: FM11260 Expires: 07/11/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Halimo Adan
Person In Charge

Signed: _____

Jeff Johanson