Electronically Delivered

December 7, 2023

Licensee
Delight Home Healthcare, LLC
8017 North College Park Drive
Brooklyn Park, MN 55445

RE: Project Number(s) SL35853015

Dear Licensee:

On November 29, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 25, 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, Supervisor
State Evaluation Team
Email: jessie.chenzie@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Electronically Delivered

November 6, 2023

Licensee
Delight Home Healthcare, LLC
8017 North College Park Drive
Brooklyn Park, MN 55445

RE: Project Number(s) SL35853015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 25, 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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by 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
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55155

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35853	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHT HOME HEALTHCARE LLC	8017 NORTH COLLEGE PARK DRIVE BROOKLYN PARK, MN 55445

(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: SL35853015-0 On October 23, 2023, through October 25, 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 (4) active residents receiving services under the Assisted Living license. An immediate correction order was identified on October 24, 2023, issued for SL35853015-0, tag identification 1290. On October 25, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 24, 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		
0 550 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 2 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 the required information related to the grievance procedure. This had the potential to affect all future 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: The licensee lacked a posting of the grievance procedure to include the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. On October 23, 2023, at 11:15 a.m., the surveyor observed the common areas shared by residents, staff and visitors lacked the required posting of	0 550		

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0 550	Continued From page 3 the grievance procedure. On October 23, 2023, at 11:20 a.m., clinical nurse supervisor (CNS)-A stated licensee had posted her phone number and thought that was sufficient. The licensee's Complaint and Investigation Process policy dated August 1, 2021, indicated to ensure complaints are resolved in a timely and appropriate manner for employees or residents that have concerns or complaints. The policy lacked verbiage to include name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 4 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all future residents under the assisted living license. 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's undated EPP lacked evidence of the following required content: - EP program patient population; - subsistence needs for staff and residents including emergency lighting; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for medical documents;	0 680		

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0 680	Continued From page 5 - policies and procedures for volunteers; - roles under a wavier declared by secretary; - sharing information on occupancy/needs; - LTC family notifications; - arrangements with other facilities; - integrated health systems; and - emergency officials contact information including Minnesota Office of Ombudsman for Long Term Care (OOLTC). On October 25, 2023, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated licensee reviewed the EPP and was in the process of updating it to reflect the requirement. The licensee's Emergency Management Policy dated August 1, 2021, indicated [licensee] will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each	0 780		

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0 780	Continued From page 6 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: The licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On October 23, 2023, at approximately 11:20 a.m., survey staff toured the Clinical Nurse Supervisor (CNS)-A. During the facility tour,	0 780		

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0 780	Continued From page 7 survey staff observed the following: It was observed that upon testing, the smoke alarms in the facility were not interconnected, so the actuation of one smoke alarm would cause all other alarms in the facility to actuate. It was also observed that sleeping room #5 in the lower level was not equipped with a smoke alarm. This deficient condition was visually verified by CNS-A accompanying the tour. 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: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all 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) and was issued at a	0 800		

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0 800	Continued From page 8 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 23, 2023, at approximately 11:20 a.m., survey staff toured the Clinical Nurse Supervisor (CNS)-A. During the facility tour, survey staff observed the following: In the bathroom on the lower level, it was observed that the ceiling fan was not working and was missing the fan cover, exposing the fan. It was observed that the ceiling fan on the main level did not work. On the door from the kitchen to the deck, it was observed that the sliding door handle was missing on the egress side. The door was marked as an emergency egress exit on the posted evacuation plan. During the facility tour, CNS-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 9 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: The licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide a maintained fire safety and evacuation plan that showed the location and number of resident rooms and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 10 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: An interview and record review were conducted on October 25, 2023, at approximately 12:00 p.m. with the Clinical Nurse Supervisor (CNS)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. It was observed that the posted fire safety and evacuation plan on the lower level was not accurate depictions of the egress route and did not match the current facility layout. On the posted lower-level evacuation plan, it was shown two bedrooms only. During the facility tour, it was observed that the facility added a bedroom in the previous living room area on the lower level. It was also observed that the posted fire safety and evacuation plan did not show the location and number of resident rooms. Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. Review of the available documentation and the staff training document provided by CNS-A contained the following discrepancies: - The policy states that residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility is a residential home and	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 does not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The policy states that when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility does not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also does not have a fire alarm system that supports the use of magnetic door holders. - The policy states that the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. This deficient condition was visually verified by CNS-A accompanying the tour. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted in March 2023 at 10:00 a.m., May 2023 at 1:00 p.m., July 2023 at 10 a.m., and September 2023 at 12 p.m., with no further drills being documented. Provided documentation indicated that the facility provided drills for the first shift only and failed to provide two drills on the second shift. The facility operated under two shifts. CNS-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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	35853	A. BUILDING: _____ B. WING _____	10/25/2023

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0 910	Continued From page 12	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R3). This had the potential to affect all residents living in the assisted living 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 the potential to affect a large portion or all the residents). The findings include: R1's Assisted Living Contract was signed on August 1, 2021. R3's Assisted Living Contract was signed on August 1, 2021.	0 910		

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0 910	Continued From page 13 R1and R3's Assisted Living Contracts lacked documentation of the Health Facility Identification (HFID) number of the facility in a conspicuous place and manner. On October 25, 2023, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated licensee was not aware of the requirement and all resident contracts would be missing the HFID number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. 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 include language waiving the licensee's liability for health, safety, or personal property of a resident for one of one resident (R1). This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 970		

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0 970	Continued From page 14 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: R1's Assisted Living Contract was signed August 1, 2021. The contract had a section with a liability language: - Section indemnification read - [licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]. On October 25, 2023, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated licensee was not aware of the liability language used in the contract and the same contract was used for all licensee's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290		

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01290	Continued From page 15 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license prior to staff providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate order for correction on October 24, 2023, at approximately 3:00 p.m. The findings include: ULP-B ULP-B started employment with licensee May 13, 2019, under the former comprehensive license	01290	On October 25, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	

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01290	Continued From page 16 and started providing assisted living services August 1, 2021. On October 24, 2023, from 7:28 a.m. to 10:20 a.m., the surveyor observed ULP-B administer medications to licensee's residents, prepare breakfast, and complete house chores. ULP-B's Final Registry Results Form dated May 1, 2019, indicated ULP-B was cleared and affiliated to HFID 33584, not the licensee's HFID 35853. On October 24, 2023, at 11:53 a.m., the surveyor with clinical nurse supervisor (CNS)-A checked the licensee's NETStudy 2.0 account (Department of Human Services web application for background studies) and ULP-B's name was missing from the licensee's roster. On October 24, 2023, at 11:57 a.m., further review of the NetStudy 2.0 website indicated ULP-B had a background study completed with the licensee's former comprehensive license, which was no longer active, on May 1, 2019, under HFID 33584, and showed a separation on May 18, 2023. ULP-D ULP-D started employment with licensee on November 11, 2021, to provide assisted living services. ULP-D's Background Study Clearance letter dated November 7, 2021, indicated ULP-D's background was completed, cleared, and affiliated to licensee's HFID 35853. On October 24, 2023, at 12:00 p.m., the surveyor with CNS-A checked licensee's NETStudy 2.0	01290		

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01290	Continued From page 17 account and ULP-D's name was missing from the licensee's roster. On October 24, 2023, at 12:05 p.m., a review of the NetStudy 2.0 website indicated ULP-D's background was completed during the COVID-19 pandemic and expired on December 31, 2022. The website also indicated of the licensee's 55 staff listed on the roster, seven (7) additional staff had expired background studies as well. On October 24, 2023, at 12:40 p.m., CNS-A stated the licensee's NETStudy 2.0 account roster was dropping older employees, and licensee was not sure why that was happening. CNS-A also stated the employees currently on the roster were affiliated recently. The Minnesota Department of Human Services website indicated the following: Emergency studies are no longer valid. Individuals who only have an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and	01290		

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01290	Continued From page 18 - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The Licensee's Background Studies policy dated August 1, 2021, indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees, volunteers, and contractors at each licensed assisted living community. The policy also indicated no employee will provide direct services and have contact with residents until acceptable results have been received. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the	01440		

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01440	Continued From page 19 interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for two of two employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP-B ULP-B started employment with licensee on May 13, 2019, under the former comprehensive license and started providing assisted living services August 1, 2021. On October 24, 2023, from 7:28 a.m. to 10:20 a.m., the surveyor observed ULP-B administer medications to licensee's residents, prepare breakfast, and complete house chores.	01440		

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01440	Continued From page 20 ULP-D ULP-D started employment with licensee on November 11, 2021, to provide assisted living services. R1's Medication Administration Summary dated between October 1, 2023, to October 20, 2023, indicated ULP-D administered medications. ULP-B and ULP-D's employee records lacked evidence a RN conducted direct supervision of ULP-B and ULP-D while performing delegated nursing tasks when the services are being provided to verify that the work was being performed competently and to identify problems and solutions related to ULP-B and ULP-D's ability to perform the tasks. On October 24, 2023, at 9:25 a.m., ULP-B stated RN trained her to administer medication by checking the six medication rights. ULP-B also stated the RN occasionally came by to observe during medication pass to ensure competency. On October 24, 2023, at 10:40 a.m., clinical nurse supervisor (CNS)-A stated all ULPs receive supervision while performing delegated tasks. CNS-A also stated it was documented in Rtask (documenting software) but without the dates when the supervisions were completed. When the surveyor requested for the supervision documentation, CNS-A provided a Staff Supervision Summary that was unsigned and undated. The licensee's Supervision of ULP policy dated August 1, 2021, indicated supervision of the ULP would be completed where the services are being provided to verify the work is performed competently and to identify problems and	01440		

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01440	Continued From page 21 solutions related to person's ability to perform the task. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced	01530		

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01530	Continued From page 22 by: Based on interview and record review, the licensee failed to ensure all staff received eight (8) hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for two of two employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP-B started employment with licensee on May 13, 2019, under the former comprehensive license and started providing assisted living services August 1, 2021. ULP-D started employment with licensee on November 11, 2021, to provide assisted living services. ULP-B and ULP-D's Assisted Living and Competencies Manual dated December 12, 2022, and January 31, 2023, indicated ULP-B and ULP-D had completed classroom post-tests in dementia training in the following topics, but lacked the number of hours for each completed module: - an explanation of Alzheimer's and other dementias; - assistance with activities of daily living; - problem solving challenging behaviors;	01530		

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01530	Continued From page 23 - communication skills; and - person centered planning and service delivery. On October 25, 2023, at 2:45 p.m. clinical nurse supervisor (CNS)-A stated ULP-B and ULP-D completed their dementia training, but she could not tell how many hours of training they obtained in each training module. CNS-A also stated it was the same for all of the licensee's employees. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees would have completed at least eight hours of initial education within 160 working of the employment start date in the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
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	01620		

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01620	Continued From page 24 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment not to exceed 90 calendar days from the date of the last review for two of two residents (R1 and 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) 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 R1's Service Plan (Waiver) - Addendum to Contract dated August 1, 2021, indicated R1 received the following services: monitoring and	01620		

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01620	Continued From page 25 assessment, medication administration, and oxygen. R1's record had three (3) Clinical Update Assessments dated February 25, 2023, May 28, 2023, and August 26, 2023. R1's ongoing resident assessment dated May 28, 2023, was 92 days since the last assessment completed on February 25, 2023. R3 R3's Service Plan (Waiver) - Addendum to Contract dated August 1, 2021, indicated R3 received the following services: monitoring and assessment, medication administration, and oxygen. R3's record had three (3) Clinical Update Assessments dated April 2, 2023, July 2, 2023, and September 30, 2023. R3's ongoing resident assessment dated July 2, 2023, was 91 days since the last assessment completed on April 2, 2023. On October 25, 2023, at 10:45 a.m., clinical nurse supervisor (CNS)-A state Rtask (documenting software) alerted the licensee's nurse when assessments were due, but the nurse could wait until the assessments were past due the 90-day mark before completing them. The licensee's Nursing Assessment Schedules policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring will be completed in person as needed based on changes in the needs of the resident but cannot exceed 90 calendar days from the last date of the assessment. No further information provided.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35853	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHT HOME HEALTHCARE LLC	8017 NORTH COLLEGE PARK DRIVE BROOKLYN PARK, MN 55445

(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
01620	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

DEPARTMENT OF HEALTH

Type: Full
Date: *10/24/23*
Time: 12:12:24
Report: 1036231271

Food and Beverage Establishment Inspection Report

Location:
Delight Home Healthcare Llc
8017 North College Park Drive
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0039426
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124141804
ID #:

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

The following orders were issued during this inspection.

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

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

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

OBSERVED RAW ANIMAL FOODS SUCH AS SHELL EGGS STORED OVER READY TO EAT FOODS IN REFRIGERATOR. DISCUSSED PROPER FOOD STORAGE.

Comply By: 10/23/23

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened 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. The date must not exceed the manufacturer's use-by-date.

OBSERVED AN OPEN PACKAGE OF SALAMI IN THE FRIDGE WITH NO DATE LABEL. ISSUE CORRECTED ON SITE.

Corrected on Site

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *10/24/23*
Time: 12:12:24
Report: 1036231271
Delight Home Healthcare Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -10 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS BENARD NYANGENA. INSPECTION CONDUCTED IN PRESENCE OF NKEIRUKA OKONKWO, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH 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.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- THERMOMETER USE AND CALIBRATION
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER
- PEST MANAGEMENT

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: *10/24/23*
Time: 12:12:24
Report: 1036231271
Delight Home Healthcare 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 inspection report number 1036231271 of 10/24/23.

Certified Food Protection Manager: OBINNA C. OKONKWO

Certification Number: FM113540 Expires: 10/17/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
NKEIRUKA OKONKWO
PERSON IN CHARGE

Signed: _____
Jeff Johanson