Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 30, 2024

Licensee
Kingsway Healthcare Services LLC
9248 Queens Garden North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35664015

Dear Licensee:

On August 14, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 27, 2024, survey were corrected. This follow-up survey verified that the facility is back in 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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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Electronically Delivered

July 23, 2024

Licensee
Kingsway Healthcare Services LLC
9248 Queens Garden North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35664015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 27, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

0830 - 144g.45 Subd. 3 - Local Laws Apply - $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35664	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY HEALTHCARE SERVICES LLC	9248 QUEENS GARDEN N BROOKLYN PARK, MN 55443

(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 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: SL#35664015 On June 24, 2024, through June 27, 2024, 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 4 residents; 4 receiving services under the Assisted Living license. On June 24, 2024, an immediate correction order was issued for tag identification 0830. The immediacy of the order and noncompliance remained at the time of exit on June 27, 2024.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 24, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

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0 550	Continued From page 2 procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Offices of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During a facility tour on June 24, 2024, at approximately 10:05 a.m., the surveyor observed	0 550		

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0 550	Continued From page 3 the common areas shared by residents, staff, and visitors, lacked the required posting of the grievance procedure and contact information for the Ombudsman. On June 24, 2024, at approximately 10:10 a.m., licensed assisted living director (LALD)-A acknowledged the required content was not posted in the common areas and was not aware of the posting requirement. The licensee's 2.10 Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee would post information about licensee's compliant/grievance procedure and the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: R2 was admitted on October 10, 2021. R2's IAPP dated June 21, 2024, indicated R2 was at risk to be abused and did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; -the resident's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On June 24, 2024, at 3:45 p.m., licensed assisted living director (LALD)-A confirmed R2's IAPP did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. LALD-A stated was not aware of the required contents of the IAPP and the IAPP was completed based on the questions shown in the electronic health record (RTasks).	0 630		

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0 630	Continued From page 5 The licensee's undated Abuse Prevention Plan policy indicated the licensee developed individualized vulnerable adult abuse prevention plans to identify risks and develop measures to minimize maltreatment based on identified information. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content to include the 911 emergency number in common areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 6 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 24, 2024, at 10:05 a.m., during the facility tour, the surveyor observed the main areas of the facility with licensed assisted living director (LALD)-A. The surveyor did not observe the 911 emergency number posted near a cordless telephone located in the living room. On June 24, 2024, at 10:10 a.m., LALD-A stated the cordless telephones could be used by staff, residents, or visitors. On June 24, 2024, at 10:15 a.m., LALD-A stated was unaware of the requirement for the 911 emergency number to be posted near the cordless telephones in the common areas. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, indicated the licensee would post 911 emergency number in common areas near telephones provided by the assisted living facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		

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0 650	Continued From page 7	0 650		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document a completed TB baseline screening at time of hire for one of one employee (unlicensed personnel (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number	0 650		

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0 650	Continued From page 8 of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on January 1, 2022. ULP-D's employee record lacked documentation of a completed TB baseline screening at time of ULP-D's hire. On June 24, 2024, at 1:45 p.m., licensed assisted living director (LALD)-A stated ULP-D received TB baseline screening at time of hire but had no record of a completed TB screening for ULP-D at time of hire. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated baseline screening is completed at time of hire for all direct care providers and testing results will be kept in each employee medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information provided. TIME PERIOD FOR CORRECTION:	0 650		

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0 650	Continued From page 9 Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents.	0 680		

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0 680	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 24, 2024, at approximately 12:00 p.m., licensed assisted living director (LALD)-A provided a binder and stated the contents were the licensee's EPP. The licensee's EPP, undated, lacked an individualized plan to include all the required content below: -missing annual review; -missing resident policy quarterly review; -development of all policies/procedures (P/P) based on HVA assessment; -emergency officials contact information; -methods for sharing information; -LTC family notifications; and -EP training and testing program. On June 24, 2024, at approximately 1:00 p.m., licensed assisted living director (LALD)-A acknowledged the licensee's EPP lacked the above listed required content. LALD-A stated the licensee's EPP was a work in progress and was not aware of all the requirements of Appendix Z. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's EPP would include all required elements of appendix	0 680		

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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
0 680	Continued From page 11 Z, reviewed annually, and based on assisted living-based and community-based risk assessments, utilizing an all-hazards approach. No further information 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 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	0 780		

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	35664	A. BUILDING: _____ B. WING _____	06/27/2024

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0 780	Continued From page 12 by: Based on observation and interview, the licensee failed to provide smoke alarms inside all sleeping rooms throughout the facility. 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 June 24, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. Survey staff tested the smoke alarms throughout the home. It was observed that a smoke alarm was not installed in bedroom #4 on the upper level. These deficient conditions were visually verified by LALD-A accompanying on the tour. During interview on June 26, 2024, at 1:00 p.m., LALD-A stated they understood the requirement for the smoke alarm and would get it installed. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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0 790	Continued From page 13 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 24, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed that the portable fire extinguishers throughout the facility lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. Documentation is required to demonstrate fire	0 790		

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0 790	Continued From page 14 extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. During interview on June 26, 2024, at 1:00 p.m.survey staff explained to LALD-A that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-A verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 15 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 16 On June 24, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Policy", "Fire Emergency Plan", "Fire Safety, Evacuation Plan, Fire Drills", and "Additional Safety Procedures for Emergencies", undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on June 26, 2024, at 1:00 p.m., LALD-A stated they understood the areas of the policy that were incomplete and would work on bringing them into compliance. TRAINING	0 810		

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0 810	Continued From page 17 Record review indicated the licensee failed to provide evacuation training to residents at least once per year. The provided records indicated that residents were trained on the FSEP at intake, but no other training records were available. All residents had been living at the facility for more than twelve (12) months. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided records indicated that staff were trained upon hire on the FSEP, but no other training records were available. All staff had been employed at the facility for more than six (6) months. During an interview on June 26, 2024, at 1:00 p.m., LALD-A stated they were providing all the required training, but did not have it documented. LALD-A stated they understood the requirements for training and documentation and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable	0 830		

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0 830	Continued From page 18 state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R3). 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 the potential to affect a large portion or all of the residents). The findings include: On June 24, 2024, at 9:15 a.m., surveyor observed a designated smoking area by the facility's front entrance with a metal cigarette disposal receptacle located on the facility's front porch. On June 24, 2024, at 10:15 a.m., surveyor observed R3's room with multiple crushed cigarettes on the floor near R3's bed. Next to R3's bed there was a small end table containing an ashtray with loose leaf tobacco, a plastic cup containing multiple cigarette butts that had been burned down to the filter of the cigarette in water, and an open soda can with multiple used cigarette butts. The surveyor smelled cigarette smoke. R3 admitted to the licensee on March 1, 2023, and resided in room three on the fourth level of the facility. R3's diagnoses included schizoaffective disorder (a mental health condition that involves combination of hallucinations, delusions,	0 830		

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0 830	Continued From page 19 depression and mania). R3's signed Resident Contract for Assisted Living dated March 1, 2023, indicated on page eight, section J, that there was no smoking in the licensee's facility. R3's registered nurse (RN) Assessment dated June 2, 2024, indicated R3 was assessed to smoke safely and independently without interventions. In addition, the assessment indicated R3 disposed of ashes and cigarette butts in the appropriate container outside. R3's progress notes dated June 8, 2024, at 5:09 p.m., documented by licensed assisted living director (LALD)-A, summarized a case management conference which indicated R3 had some incidents of smoking in his room. R3's Service Plan dated signed June 24, 2024, indicated R3 received assistance that included behavior management and safety checks. On June 24, 2024, at approximately 10:20 a.m., LALD-A stated that the licensee was aware of R3's smoking habit and R3 had been smoking indoors during off shifts and weekends. LALD-A also stated that R3's smoking was a fire risk that would need to be addressed. In addition, LALD-A confirmed the facility's designated smoking area was the facility's front porch area. On June 24, 2024, at approximately 2:00 p.m., R3 stated "I smoked in my room sometimes." The licensee's undated smoking policy indicated there was no smoking in the building and residents may smoke in the designated area outdoors.	0 830		

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0 830	Continued From page 20 The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy of the order and noncompliance remained at the time of exit on June 27, 2024.	0 830		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	01060		

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01060	Continued From page 21 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	01060		

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01060	Continued From page 22 Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the Office of Long-Term Care (OOLTC) for one of one resident (R4) who had an emergency relocation. 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: On June 24, 2024, at approximately 10:00 a.m., during the facility tour, licensed assisted living director (LALD)-A stated R4 was currently admitted to rehab and had been for more than three weeks. R4 was admitted on April 20, 2022. R4's Progress Notes dated May 28, 2024, indicated R4 was transported and admitted to a residential treatment facility for thirty (30) days. R4's record lacked documentation the licensee provided an emergency relocation written notification as required to the OOLTC. On June 24, 2024, at approximately 2:15 p.m., LALD-A stated the licensee was not aware of the required emergency relocation notice to R4's Ombudsman when the emergency relocation was longer than four days.	01060		

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01060	Continued From page 23 The licensee's 1.23 Emergency Relocation policy dated October 1, 2021, indicated the required written notice with the required content for an emergency relocation would be provided to the OOLTC if the resident has been relocated longer than four (4) days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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	03090		

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03090	Continued From page 24 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 June 24, 2024, at 09:15 a.m., upon entering the facility, the surveyor observed one entrance accessible by visitors to the facility and it lacked the required notice for electronic monitoring. On June 24, 2024, at approximately 10:00 a.m. during a facility tour, multiple cameras were noted throughout the facility. On June 24, 2024, at 10:05 a.m., licensed assisted living director (LALD)-A stated the licensee was not aware of the required verbatim notice to be posted at the entrance accessible by visitors. LALD-A also stated the required electronic monitoring posting would need to be placed at the entrance. The licensee's 2.15 Electronic Monitoring policy dated August 1, 2021, indicated the licensee would post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *06/24/24*
Time: 13:50:07
Report: 8058241153

Food and Beverage Establishment Inspection Report

Location:
Kingsway Healthcare Svcs Llc
9248 Queens Garden N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038975
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632029117
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.

3-500C 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.

INCORRECT DATE ON OPENED LUNCH MEAT - DO NOT REUSE ZIPLOCK BAGS

Comply By: 06/25/24

4-300 Equipment Numbers and Capacities

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

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

DISH THERMOMETER IS FILLED WITH WATER AND NOT ABLE TO FUNCTION - REPLACE

Comply By: 06/30/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

SOME FOOD DEBRIS IN CABINETS AND ON SURFACES

Comply By: 07/07/24

Food and Equipment Temperatures

Process/Item: DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Type: Full
Date: *06/24/24*
Time: 13:50:07
Report: 8058241153
Kingsway Healthcare Svcs Llc

Food and Beverage Establishment Inspection Report

Process/Item: STRAWBERRY
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR CARL SAMROCK
ESTABLISHMENT REP K. KANU

RESIDENTIAL KITCHEN WITH NON COMMERCIAL APPLIANCES AND FINISHES

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058241153 of 06/24/24.

Certified Food Protection Manager: MARKELL ODOM

Certification Number: 120038 Expires: 07/03/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us