



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 9, 2024

Licensee
S & H Health Care Services
4925 Sorell Avenue
Golden Valley, MN 55422

RE: Project Number(s) SL36848015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

resident(s)/employee(s) identified in the correction order.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEphVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER S & H HEALTH CARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 4925 SORELL AVENUE GOLDEN VALLEY, MN 55422			
(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: SL36848015 On June 17, 2024, through June 18, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents receiving services under the provider's Assisted Living license.	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.		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs as required. This had the potential to affect all 18 residents at the facility. 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:	0 460			

Minnesota Department of Health

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0 460	Continued From page 2 The licensee held an assisted living care license and was licensed for a bed capacity of four residents. During the entrance conference on June 17, 2024, at approximately 10:20 a.m., house manager (HM)-C confirmed the licensee did not have a call system in place for residents to request assistance when needed. HM-C confirmed that residents did have rooms in the licensee's main level and lower level of the home. HM-C stated all staff were able to hear residents should they call out for assistance due to the home being small. During the facility tour on June 17, 2024, at 11:35 a.m., the surveyor noted the licensee's residents' rooms had wood paneled doors, and each door had a doorknob that would be used to close a door. Each resident room lacked any type of calling system to notify staff when assistance would be needed. During interview on June 17, 2024, at approximately 1:45 p.m., R1 stated she did not have an alarm system on their person, their bed, or any other call system supplied by the licensee, and felt staff were not always able to hear her when she was in her room. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800			

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0 800	Continued From page 3 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 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 17, 2024, at 2:30 p.m., survey staff toured the facility with the house manager (HM)-C and owner(O)- E. During the facility tour, survey staff observed the following items: In main level bedroom #1, it was observed that the egress window glass panel was cracked. In lower-level bedroom #3, it was observed that the egress window was obstructed by a plastic well cover that was fall into the well from above, and the well cover obstructed the egress window from opening fully.	0 800			

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0 800	Continued From page 4 In lower-level bedroom #4, it was observed that the egress window was obstructed by a tree growing in the window well, and the tree obstructed the egress window from opening fully. During the facility tour at 2:30 p.m., HM-C and O-E 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; (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	0 810			

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0 810	Continued From page 5 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 the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 17, 2024, at 3:00 p.m., house manager (HM)-C provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. The FSEP did not show the location and number of resident rooms. During the tour, it was also observed that the posted evacuation plans did not	0 810			

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0 810	Continued From page 6 show the number of resident rooms. 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 FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP also instructed staff to close all doors to contain the fire, but the facility did not have a fire-rated door and wall assembly. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on June 17, 2024, at 3:00 p.m., HM-C stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

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01910	Continued From page 7	01910			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for three of three discharged residents (R2, R3, R4). 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	01910			

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01910	Continued From page 8 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: R2 was discharged from the licensee on March 28, 2024 R2's Service Plan dated June 1, 2023, indicated R2 received services to include medication administration, personal laundry, housekeeping, linen change, food preparation, and monitoring and reassessment. R3 was discharged from the licensee on December 20, 2022. R3's Service Plan dated June 9, 2022, indicated R3 received services to include medication administration, personal laundry, housekeeping, linen change, food preparation, and monitoring and reassessment. R4 was discharged from the licensee on September 30, 2022. R4's Service Plan dated July 1, 2022, indicated R4 received services to include medication administration, personal laundry, housekeeping, linen change, food preparation, and monitoring and reassessment. R2, R3, and R4's records lacked documentation of the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the	01910			

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01910	Continued From page 9 disposition. During interview on June 17, 2024 at 1:40 p.m., house manager (HM)-C acknowledged R2, R3, and R4's records were missing the required content above and stated the medications were sent with the residents when they discharged but HM-C was not aware of the statute requirements. The licensee's Medication Disposal policy dated August 1, 2021, noted upon disposition, the licensee would document the following information in the clinical record: the name, strength, and prescription number of medications as applicable; quantity; to whom the medications were given; the date of disposition; and the names of staff (including a witness) and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

Type: Full
Date: 06/18/24
Time: 12:26:29
Report: 7963241049

Food and Beverage Establishment Inspection Report

Page 1

Location:

S & H Health Care Services
4925 Sorell Avenue
Golden Valley, MN55422
Hennepin County, 27

Establishment Info:

ID #: 0038643
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122279178
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: CREAM
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

MET WITH ESTABLISHMENT REPRESENTATIVE HABON UGAAS. MDH NURSE SURVEYOR ELYSE JONES WAS NOT ON SITE AT TIME OF INSPECTION.

DISCUSSED THE FOLLOWING-

- EMPLOYEE ILLNESS POLICY AND LOG
- HAND WASHING
- SANITIZING DISHES
- THERMOMETERS

THIS IS A RESIDENTIAL HOME THAT DOES SAME-DAY MEAL SERVICE. IT HAS A RESIDENTIAL DISHWASHER WITH A SANITIZER CYCLE.

Type: Full
Date: 06/18/24
Time: 12:26:29
Report: 7963241049
S & H Health Care Services

Food and Beverage Establishment Inspection Report

Page 2

FLOOR IS LINOLEUM, CABINETS ARE WOOD, COUNTERTOP IS LAMINATE AND CEILING IS SMOOTH AND PAINTED.

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 7963241049 of 06/18/24.

Certified Food Protection Manager Habon Ugaas

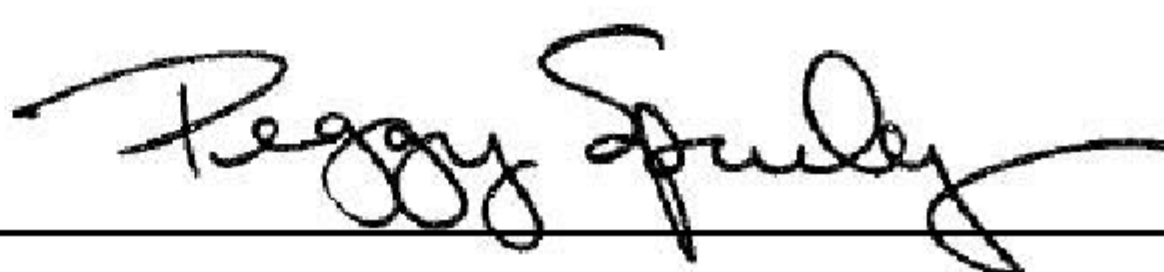
Certification Number: FM 112197 Expires: 08/07/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Habon Ugaas
PIC

Signed: _____



Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us