DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 3, 2024

Licensee
Miles Vents Inc.
7124 Fremont Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL37143015

Dear Licensee:

On October 28, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 14, 2024, 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,

Benjamin Zwart

Benjamin J. Zwart, Supervisor
State Evaluation Team
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

September 13, 2024

Licensee
Miles Vents Inc.
7124 Fremont Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL37143015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 14, 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.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

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

The correction order documentation should include the following:

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

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

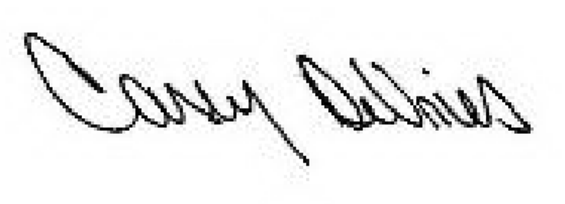
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37143	A. BUILDING: _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INC	7124 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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: SL37143015-0 On August 12, 2024, through, August 14, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements	0 485		

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0 485	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to offer at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. 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 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	0 485		

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0 485	Continued From page 2 The findings include: On August 12, 2024, at 10:20 a.m., during the entrance conference clinical nurse supervisor (CNS)-A stated the licensee served three meals per day, served per Minnesota Food Code. On August 12, 2024, at 12:48 p.m., the surveyor observed unlicensed personnel (ULP)-D serve a lunch meal to the residents. The meal consisted of an egg and a hotdog sandwich with ketchup. On August 13, 2024, at 12:30 p.m., the surveyor observed ULP-D serve R1 a lunch that consisted of an egg sandwich and a hotdog. In both days the meals lacked seasonal fresh fruits and fresh vegetables. On August 13, 2024, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee had yet to do shopping for the week. The USDA My Plate Guide dated September 1, 2022, indicated half the plate should be fruits and veggies as they are packed with fiber and antioxidants. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510		

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0 510	Continued From page 3 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for hand washing for one of one unlicensed personnel (ULP)-D. This had the potential to affect all 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) 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-D began employment with the licensee to provide assisted living services September 9, 2022. On August 12, 2024, at 12:35 p.m., the surveyor observed ULP-D answer a phone call then head to R3's room to inform R3 of a provider appointment. Without performing hand hygiene, ULP-D opened the medication cart, pulled out R3's medications and prepared them in a	0 510		

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0 510	Continued From page 4 medication cup then handed them to R3 to take with a glass of water. On August 12, 2024, at 12:40 p.m., the surveyor observed ULP-D prepare R4's medications before washing hands and offered them to R4 to take with a glass of water. On August 12, 2024, at 1:30 p.m., ULP-D stated they were trained to wash hands before handling resident medications. On August 12, 2024, at 1:40 p.m., clinical nurse supervisor (CNS)-A stated all staff were trained in infection control procedures including washing hands before handling resident medication and food. The Centers for Disease Control and Prevention's Hand Hygiene in Healthcare Settings last reviewed January 30, 2020, indicated healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: - immediately before touching a patient; - before performing an aseptic task; - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or the patient's immediate environment; - after contacting with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. The licensee's Infection Control policy dated August 1, 2021, indicated hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between resident contacts, and when indicated to prevent transfer of microorganisms between resident or	0 510		

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0 510	Continued From page 5 the environment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	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 ensure employee records contained the required content for two of two	0 650		

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0 650	Continued From page 6 employees unlicensed personnel ((ULP)-D, ULP-E). 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: ULP-D ULP-D started employment with the licensee to provide assisted living services September 6, 2022. ULP-D's employee record lacked evidence of the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-E ULP-E started employment with the licensee to provide assisted living services March 5, 2024. ULP-E's employee record lacked evidence of the following required content: - documented supervision within 30 days of performing delegated tasks. ULP-E's record lacked the following required content for training: - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural	0 650		

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0 650	Continued From page 7 background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - awareness of commonly used health technology equipment and assistive devices; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-E's record lacked the following required content for competency evaluations: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and - other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On August 13, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated the licensee was using paper documentation and they were not able to track down the missing records. Also, CNS-A stated they had just started using Rtask (training software) and they would be able to maintain	0 650		

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0 650	Continued From page 8 employee training going forward. On August 13, 2024, at 2:30 p.m., registered nurse (RN)-B stated the licensee trained all staff on competencies and return demonstration was completed for all ULPs, but the licensee did not document. On August 13, 2024, at 2:36 p.m., ULP-E stated they were trained by the RN in the office and at the facility. The RN demonstrated and requested ULP-E to perform a return demonstration before they started to shadow another ULP for almost a month before working alone. On August 13, 2024, at 3:20 p.m., CNS-A stated the licensee needed to have a system in place to track employee annual performance reviews. Also, stated all 30-day supervisions were completed except the record missing. The licensee's Staff Competency policy dated August 1, 2021, indicated ULP may not work for [licensee] until they have successfully passed the written (at 80%) and demonstration competency evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 9 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The facility TB risk assessment form dated February 2, 2024, indicated the facility was at a low risk for TB transmission.	0 660		

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0 660	Continued From page 10 ULP-E started employment with the licensee to provide assisted living services March 5, 2024. ULP-E's employee record included a TB history and symptom screen completed on January 30, 2024, and a two-step tuberculin skin test (TST) with the first step skin test completed on February 2, 2024, with a negative result. ULP-E's record lacked a second step skin test. On August 13, 2024, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated ULP-E was newly employed, and the licensee had not completed a second step. The Minnesota Department of Health's Assisted Living Resources & Frequently Asked Questions (FAQs) last updated April 3, 2024, indicated baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated [licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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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	0 680		
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 interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. In addition, the licensee failed to provide building emergency exit diagrams to all residents. This had the potential to affect all residents receiving services under the assisted living license.	0 680		

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	37143	A. BUILDING: _____ B. WING _____	08/14/2024

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0 680	Continued From page 12 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 August 12, 2024, at 11:26 a.m., during the licensee's building tour the surveyor requested to know whether the residents had been provided with the building emergency exit diagrams. Clinical nurse supervisor (CNS)-A stated the licensee was not aware of the requirement. The licensee's undated, emergency preparedness plan lacked the following required content: - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a waiver declared by secretary; and - emergency prep testing requirements. On August 13, 2024, at 3:10 p.m., CNS-A stated the licensee was still working on updating their EPP to be compliant with state requirements. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.	0 680		

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0 680	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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 a facility tour on August 13, 2024, from 10:00	0 800		

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0 800	Continued From page 14 a.m. to 10:45 a.m., with licensed assisted living director (LALD)-A, and registered nurse (RN)-B, the surveyor made the following observations of facility hazard or disrepair: The door leading from the assisted living to the attached garage was marked with an exit sign directing occupants through the garage to exit the assisted living. The garage shall not be used as an exit route from the assisted living as the garage is an area of higher hazard than the assisted living in accordance with current Minnesota Fire Code. The marked exit door leading from the assisted living into the garage was provided with a lock requiring a key to open from the egress side of the door. All marked exit doors in the exit route are required to open from the egress side in the direction of travel to the exterior exit without the use of tools, keys, or special knowledge. The exterior bottom step measured 9.5 inches high, and the top step measured 7.5 inches high, on the stairway outside the main front required exit door. The required exit steps in a flight of stairs are required to be equal and no more than 3/8-inch variation between steps in accordance with current Minnesota Fire Code. There was construction debris and new construction materials in the garage. During an interview on August 13, 2024, at 10:30 a.m., RN-B, stated they were installing new flooring, painting in the basement, and replacing kitchen cabinets. All construction work and alterations to an assisted living are required to be submitted to Minnesota Department of Health and the local building code department for approval prior to starting the work.	0 800		

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0 800	Continued From page 15 There was an additional smoke alarm that did not work when tested in resident sleeping room 2. Smoke alarms that are installed are required to be maintained in working condition in accordance with current Minnesota Fire Code. The resident room numbers installed on the doors of resident room 2 and 3 did not match the room numbers as provided on the facility evacuation floor plan. There were also no resident room numbers on the rooms in the basement matching the evacuation floor plan provided. The numbers installed on the resident room doors are required to match the numbers on the evacuation floor plan in order to direct building occupants to an exit in the event of a fire or similar emergency. The window well cover was contacting the top of the window when opening, preventing the window from opening fully under normal operation of the window hardware in resident room 4, and 5. During a facility tour on August 13, 2024, at 10:40 a.m., LALD-A, and RN-B, verified the above listed observations while accompanying on the tour. 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 16 (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: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. 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	0 810		

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0 810	Continued From page 17 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 potential to affect a large portion or all of the residents). The findings include: On August 13, 2024, from 10:00 a.m. to 10:45 a.m., with licensed assisted living director (LALD)-A, and registered nurse (RN)-B, 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 provided FSEP dated August 7, 2024, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures in writing in the FSEP for review of building occupants. During an interview on August 13, 2024, at 9:45 a.m., LALD-A, and RN-B, stated the FSEP resident actions/ procedures for residents in the event of a fire or similar emergency was verbally delivered to residents but not provided in writing in the FSEP. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation FSEP was provided to employees	0 810		

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0 810	Continued From page 18 separate from fire drills. During an interview on August 13, 2024, at 9:45 a.m., LALD-A, and RN-B, stated the FSEP training for employees was completed along with the fire drills and not documented as separate training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, visitors, 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	0 820		

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0 820	Continued From page 19 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). Findings include: On a facility tour on August 13, 2024, from 10:00 a.m. to 10:45 a.m., the following distinct hazards were observed: There was used cigarette smoking materials, and ash, and burn marks on the top of the dresser in resident room 3, as identified on the facility evacuation plan map. Used cigarette smoking material is required to be discarded in an appropriate container in the designated smoking area in accordance with the licensee smoking policy. These deficient conditions were visually verified by LALD-A, and RN-B, accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
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;	0 910		

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0 910	Continued From page 20 (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 all licensee's residents. 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 potential to affect a large portion or all the residents). The findings include: On August 12, 2024, at 11:50 a.m., clinical nurse supervisor (CNS)-A provided the surveyor with the licensee's blank contract and stated the same contract was given to all the licensee's residents. The licensee's Assisted Living Contract lacked documentation of the Health Facility Identification (HFID) number in a conspicuous place and manner. On August 12, 2024, at 2:30 p.m., 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.	0 910		

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0 910	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
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 by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working	01530		

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01530	Continued From page 22 hours of the employment start date for two of two direct care employees (unlicensed personnel (ULP)-D, ULP-E). 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: ULP-D ULP-D started employment with the licensee to provide assisted living services September 6, 2022. ULP-D lacked eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date to include: - 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. ULP-E ULP-E started employment with the licensee to provide assisted living services March 5, 2024. ULP-E's My Transcript dated February 5, 2024, and February 6, 2024, indicated ULP-E completed initial dementia training for a total of three hours in the following topics: - dementia activities - 0.5 credits;	01530		

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01530	Continued From page 23 - dementia activities a balanced approach - 0.75 credits; - dementia communication overview - 1 credits; and - dementia overview Alzheimer's disease - 0.75 credits. ULP-E's record lacked the required at least eight hours of initial dementia training. On August 13, 2024, at 10:50 a.m., ULP-D stated they were trained in dementia care but could not remember the topics and number of hours of training. On August 13, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated the licensee did not maintain employee training records. Also, CNS-A stated the licensee did not have a dementia training manual. The licensee's Dementia Education policy dated August 1, 2021, indicated all staff providing care in [licensee] will be knowledgeable in how to provide safe, effective services related to dementia. Also, indicated all the required dementia topics would be covered. No further information 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	01620		

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01620	Continued From page 24 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments to include all areas required on the uniform assessment tool for one of one resident (R2). 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:	01620		

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MILES VENTS INC	7124 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430

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01620	Continued From page 25 R2 was admitted to the licensee and began receiving assisted living services on September 8, 2021. R2's diagnoses included schizoaffective disorder, borderline personality disorder, and opioid dependence. R2's Signed Care Plan dated September 8, 2021, indicated R2 received assistance with dressing, grooming, meal preparation, daily vitals, nursing assessments, and medication administration. R2's record included nurse assessment visits form completed on May 15, 2024, June 14, 2024, and a post hospital assessment completed on June 27, 2024. R2's assessments failed to include the elements identified in a uniform assessment tool to include the following: - the resident's personal lifestyle preferences; - activities of daily living; - instrumental activities of daily living; - cognition; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; and - who has decision-making authority for the resident. On August 13, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-A stated they were not aware their assessment forms were missing required details until recently. Also, CNS-A stated they were working to update the forms; however, they	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37143	A. BUILDING: _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INC	7124 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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 had not started using the new forms on any of their resident assessments yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of three residents (R2). 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: R2 was admitted the licensee on September 8, 2021, and began receiving assisted living services.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37143	A. BUILDING: _____ B. WING _____	08/14/2024

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MILES VENTS INC	7124 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430

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01890	Continued From page 27 R2's Signed Care Plan dated September 8, 2021, indicated R2 received assistance with dressing, grooming, meal preparation, daily vitals, nursing assessments, and medication administration. On August 13, 2024, at 11:50 a.m., the surveyor observed a medication closet which contained the following expired medications for R2: - triple antibiotic ointment apply topically to affected areas three times daily - discard October 2, 2023. - Eucerin cream apply to affected areas four times daily - discard October 2, 2023. - diclofenac sodium topical gel 1% apply to chest twice daily as needed for pain - expired May 5, 2023. - two boxes Ventolin hfa 90 microgram (mcg) per actuation - expired October 2023. - diphenhydramine 50 milligram (mg) capsules take one capsule by mouth every six hours as needed - expired October 1, 2023. On August 13, 2024, at 1:48 p.m., clinical nurse supervisor (CNS)-A stated expired meds were disposed of through the licensee's pharmacy. CNS-A stated the medication closet was checked frequently to remove expired meds and that no expired meds should be in the closet. The licensee's Disposition / Disposal of Medications policy dated August 1, 2021, indicated discontinued medication may be kept until the expiration dates if there is a possibility of resuming the medication. If not resumed before the expiration date it will be disposed of according to this policy. No further information was provided.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 28 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *08/14/24*
Time: 11:00:00
Report: 1043241205

Food and Beverage Establishment Inspection Report

Location:
Miles Vents Inc
7124 Fremont Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0038248
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632055880
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 150 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: HOT DOG
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

Inspection was completed with the Health Regulation Division. Benard Nyangena was the nurse evaluator completing the site survey. All items on the report were discussed with Aimugina Agene and three other staff members.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

If a sanitizer bucket will be used for a chlorine solution for storing wet cloths, provide a test kit to measure the solution. Cloths should be completely saturated in sanitizer before it is stored in the bucket or the concentration of the sanitizer solution may drop below the required range. Replace the sanitizer solution as much as necessary to maintain proper concentration (recommended 50-100 PPM for chlorine). Excessive

food debris, length of time, temperatures below 74/75F, and high frequency of usage can affect concentration levels.

Foods cooked in house must only be available for same day service for highly susceptible populations, discard any leftovers at the end of the day.

This facility has a residential kitchen with residential equipment. The kitchen finishes and surfaces are well maintained. Current residential dish machine (NSF/ANSI 184) has a sanitizing option which must always be used when running a cycle, ensure utensil surface temperature reaches at least 150F (or 160F for all other residential/commercial dish machines) by using a test kit at least once a week.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 1043241205 of 08/14/24.

Certified Food Protection Manager: Aimugina Agene

Certification Number: FM108143 Expires: 09/01/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Aimugina Agene
PIC

Signed: Blia Lor

Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us