Electronically Delivered

September 29, 2022

Administrator
Passionate Health Care Services, LLC
1555 Christie Place
Saint Paul, MN 55106

RE: Project Number(s) SL38060015

Dear Administrator:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial evaluation on August 19, 2022, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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 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.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health 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(a)(5)(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 evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 residents/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91 Subd. 8), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

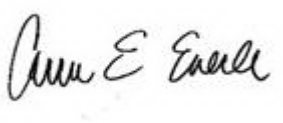
REQUESTING A HEARING

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Carrie Euerle, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: carrie.euerle@state.mn.us
Phone: 651-242-8846 Fax: 651-215-5963

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38060	A. BUILDING: _____ B. WING _____	08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASSIONATE HEALTH CARE SERVICES, LLC	1555 CHRISTIE PLACE SAINT PAUL, MN 55106

(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 Initial comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS 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#38060015 On August 15 and 16, 2022, 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 and investigation, there were 5 residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Assisted Living Provider 144G. 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.	

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0 430	Continued From page 1	0 430		
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for five of five residents (R1, R2, R3, R4, R5) with records reviewed. 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).	0 430		

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0 430	Continued From page 2 R1 had an admission date of March 1, 2022, with diagnoses that included bipolar disorder, COPD, diabetes, major depression, panic disorder, osteoporosis, and spinal stenosis. R1's care plan dated March 1, 2022, indicated R1 received services for medication management, behavior monitoring, bathing and grooming assistance, mobility and transfer assistance, toileting assistance, housekeeping, and laundry assistance. R2 had an admission date of April 7, 2022, with diagnoses that included diabetes, encephalopathy, chronic pain, depression, anxiety, and agitation. R2's care plan dated April 7, 2022, indicated R2 received services for medication management, behavior monitoring, bathing, and grooming assistance, housekeeping, and laundry assistance. R3 had an admission date of April 7, 2022, with a diagnosis that included diabetes. R3's care plan dated April 7, 2022, indicated R3 received services for medication management, and housekeeping assistance. R4 had an admission date of May 24, 2022, with diagnoses that included cognitive impairment, seizure disorder, legally blind, and COPD. R4's care plan dated May 24, 2022, indicated R4 received services for medication management, behavior monitoring, housekeeping, and laundry assistance. R5 had an admission date of April 25, 2022, with diagnoses that included malnutrition, major depression, diabetes, altered mental status, CKD, psychotic disorder, and rheumatoid arthritis. R5's care plan dated April 25, 2022, indicated R5	0 430		

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0 430	Continued From page 3 received services for medication management, behavior monitoring, bathing and grooming assistance, mobility and transfer assistance, toileting assistance, housekeeping, and laundry assistance. R1's, R2's, R3's, R4's, and R5's record lacked a uniform checklist disclosure of services (UDALSA) to include: a disclosure of the categories of assisted living licenses available and the category of license held by the facility; a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license the facility did not provide; and an oral explanation of the services offered under the contract. On August 15, 2022, at 2:00 p.m. the licensed assisted living director (LALD)-D verified resident records lacked a signed UDALSA form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United	0 480		

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0 480	Continued From page 4 States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 comply with Minnesota Food Code chapter 4626. This had the potential to affect all 5 residents residing 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 13, 2021, for the specific Minnesota Food Code deficiencies.. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		

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0 510	Continued From page 5	0 510		
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 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 establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. This had the potential to affect all staff members and five of five current residents (R1, R2, R3, R4, R5) reviewed. 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). Findings Include: The licensee failed to ensure they established a process for screening visitors who entered the	0 510		

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0 510	Continued From page 6 facility. The licensee also failed to ensure staff completed COVID-19 screening before the start of their shift. The Minnesota Department of Health (MDH) guideline titled, COVID-19 Action Plan for Congregate Settings, updated April 14, 2022, indicated facilities must establish a process to screen all who enter the facility (staff, readmits, contractors, volunteers, visitors) On August 15, 2022, at 9:00 a.m., the surveyor observed there was no COVID-19 mask signage on the outside of the door or in the entryway of the facility alerting visitors a mask was needed to enter the facility. On August 15, 2022, at 9:10 a.m., the state surveyor entered the facility and was met by the licensed assisted living director (LALD)-D. No COVID-19 screening done at this time. The surveyor observed there was no station or logbook for COVID-19 screening. On August 16, at 11:30 a.m., a visitor for R2 entered the facility and was not wearing a mask and was not screened for COVID-19. On August 16, 2022, at 2:30 p.m., a case manager for R4 entered the facility. The case manager was not screened for COVID-19. The licensee failed to ensure staff wore protective eyewear while in resident care areas or when performing direct resident cares. The Centers for Disease Control (CDC) COVID Data Tracker, updated weekly, indicated on August 15, 2022, the county the facility was located in had a high community transmission	0 510		

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0 510	Continued From page 7 level. The MDH guideline titled, COVID-19 PPE and Source Control Grids, dated April 7, 2022, indicated direct care staff working with residents without suspected or confirmed SARS-CoV-2 infection wore face masks, and eye protection when working in facilities located in counties with high community transmission levels. On August 15, 2022, from 9:00 a.m. to 4:30 p.m., ULP-A and LALD-D was observed not wearing protective eyewear. On August 16, 2022, from 9:00 a.m. to 4:30. p.m., ULP-A, ULP-B, and LALD was observed not wearing protective eyewear. On August 15, 2022, at 1:00 p.m., ALAD stated the facility was just opened and that she was working on getting everything organized. ALAD stated she would post signs and begin screening for COVID-19. The licensee's policy titled, COVID-19 Recommendations for Health Care Workers, dated September 29, 2021, indicated healthcare orders should continue to wear a medical grade facemask and eye protection while at work. No further information was provided. TIME PERIOD OF CORRECTION: Two (2) Days	0 510		
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 8 procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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. 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 Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all five residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting in a common area of the grievance procedure which included the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no posting in the common area regarding contact information for the state	0 550		

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0 550	Continued From page 9 and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On August 15, 2022, during a facility tour at 9:10 a.m., the surveyor observed the facility's common areas and noted the lack of the required posting of the grievance procedure and Ombudsman contact information. When interviewed on August 15, 2022, at 2:00 p.m., Licensed assisted living director (LALD)-D stated the required information was not posted in the common areas of the facility, and that she would correct the issue. The licensee's Complaint and Investigation Process policy undated, indicated residents will be informed of their right to complain to the facility. However, it did not indicate that complaint/grievance information would be posted in a conspicuous place, with information about the complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 550		
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	0 650		

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0 650	Continued From page 10 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three unlicensed personnel (ULP), the licensed assisted living director (LALD)-D, and the administrator (Admin)-E (ULP-A, ULP-B, ULP-C, LALD-D, Admin-E) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650		

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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
0 650	Continued From page 11 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-A was hired on April 25, 2022. ULP-A's employee record lacked evidence of competency training. The record also lacked a ULP job description. ULP-B was hired on March 14, 2022. ULP-B's employee record lacked evidence of competency training. The record also lacked a ULP job description. ULP-B was hired on July 10, 2022. ULP-C's employee record lacked evidence of competency training. The record also lacked a ULP job description. LALD-D was hired on December 6, 2021. LALD-D's employee record lacked evidence of a LALD job description. LALD-D was also providing services as the registered nurse and the clinical nurse supervisor, and the employee record lacked evidence of those job descriptions as well. Admin-E was hired on December 6, 2021. Admin-E's employee record lacked evidence of an administrator job description. Admin-E was also providing services as the LPN and the employee record lacked evidence for this job description as well. On August 15, 2022, at 2:00 a.m., LALD-D stated competency training was completed for all ULP,	0 650		

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	38060	A. BUILDING: _____ B. WING _____	08/19/2022

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0 650	Continued From page 12 however she did not provide documentation of this training for the employee file. LALD-D acknowledged that all employee files were lacking job descriptions. An undated facility policy titled Job Description Policy indicated a job description must be completed on all employee positions prior to hiring for the position. Each job description will be signed by the employee and placed in their personnel file. The licensee's policy titled Qualifications, Training and Competency undated, indicated documentation of training and/or competency shall be maintained in the personnel file of each employee. No further information provided. TIME PERIOD FOR CORRECTION: 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;	0 680		

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0 680	Continued From page 13 and (5) have a written policy and procedure regarding missing tenant 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, interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all the required components included in Appendix Z. This had the potential to 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) 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 the Provisional Assisted Living Facilities (PALF) survey on August 16, 2022, at 2:00 p.m., the Licensed Assisted Living Director (LALD)-D provided a three-ring binder that contained policies that included emergency policies. LALD-D stated there was no EPP developed in	0 680		

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0 680	Continued From page 14 accordance with the new Assisted Living Licensure requirements, but the licensee was in the process of developing an EPP. The licensee's Disaster Plan lacked the following required content: -A prominently-posted emergency disaster plan -Building emergency exit diagrams provided to all residents -Establishment of the Emergency Program (EP), including: -Developing and maintaining the EP -Maintaining and including annual EP updates -EP resident population -Process for EP collaboration -Development of EP policies and procedures -Subsistence needs for residents and staff -Procedure for tracking residents and staff -Arrangement with other facilities -Roles under a waiver declared by Secretary -Development of communication plan -Names and contact information -Emergency officials contact information -Alternate means of communication -Methods for sharing information -Sharing information on occupancy/needs -Family notifications -EP training and testing -EP training program -EP testing requirements The licensee's policy included a Hazard Vulnerability Analysis Tool that was not completed along with policies and procedures related to natural disasters, as well as generic provisions on how staff should respond in various emergent situations. All policies were in accordance with comprehensive home care 144A statutes, not assisted living 144G statutes, despite the licensee operating as an assisted living facility.	0 680		

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0 680	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (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 ensure installation and maintenance of portable fire extinguishers at the facility. 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) 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 residents). The findings include:	0 790		

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0 790	Continued From page 16 On August 19, 2022 from approximately 900am to 1000am, survey staff toured the facility with Admin-E. During the facility tour, survey staff observed the fire extinguisher do not have service tags on the last inspection was completed. Admin-E verbally confirmed survey staff observations during the facility tour. Admin-E stated he did not know he had to have them service or inspect them monthly. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=E	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 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	0 800		

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0 800	Continued From page 17 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 19, 2022 from approximately 900am to 1000am, survey staff toured the facility with Admin-E. During the facility tour, survey staff observed the bathrooms did not have GFCI outlets located near the sink area per NFPA 70-210.8 (F) Admin-E verbally confirmed survey staff observations during the facility tour. He stated they had just purchase the home and all was ok at the time. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 18 (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 provide the required fire safety training and evacuation plans for residents and staff. This has 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	0 810		

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0 810	Continued From page 19 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 the potential to affect a large portion or all residents). The findings include: On August 19,2022 from approximately 900am to 10:00am, survey staff toured the facility with Admin-E. During the facility tour, survey staff observed the home did not have evacuation plan showing two ways out of each bedrooms. Admin-E verbally confirmed survey staff observations during the facility tour. During interview on August 19, 2022 at 915am, Admin-E stated he will redo the floor plan he made up and added the escape routes.. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01430 SS=F	144G.62 Subd. 3 Supervision of staff (a) Staff who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the facility having the authority, skills, and ability to provide the supervision of unlicensed personnel and who	01430		

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01430	Continued From page 20 can implement changes as needed, and train staff. (b) Supervision includes direct observation of unlicensed personnel while the unlicensed personnel are providing the services and may also include indirect methods of gaining input such as gathering feedback from the resident. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of direct supervision of unlicensed personnel (ULP) occurred for three of three (ULP-A, ULP-B, ULP-C) records reviewed. This had the potential to affect all five 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). Findings include: ULP-A was hired on April 25, 2022. ULP-A's employee record lacked evidence that direct supervision occurred 30 days after orientation and competency training to verify the ULP performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. ULP-B was hired on March 14, 2022. ULP-B's	01430		

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01430	Continued From page 21 employee record lacked evidence that direct supervision occurred 30 days after orientation and competency training to verify the ULP performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. ULP-B was hired on July 10, 2022. ULP-C's employee record lacked evidence that direct supervision occurred 30 days after orientation and competency training to verify the ULP performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. During an interview on August 15, 2022, at 2:00pm. LALD-D stated direct supervision of staff was informally conducted, and documentation of this supervision was not completed. The licensee's policy titled Supervision of Unlicensed Personnel undated, indicated the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs delegated tasks for residents, and thereafter as needed based on performance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	01430		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all	02240		

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02240	Continued From page 22 reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record.	02240		

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02240	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written acknowledgement of receipt of the current Minnesota Assisted Living Bill of Rights (BOR) and required assessments for five of five residents (R1, R2, R3, R4, R5) with records reviewed. 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 of the residents). The findings include: R1 had an admission date of March 1, 2022. R1's record lacked written acknowledgement of receipt of the Minnesota Bill of Rights for Assisted Living Residents. R1's record lacked a 14-day and 90-day assessment. R2 had an admission date of April 7, 2022. R2's record lacked written acknowledgement of receipt of the Minnesota Bill of Rights for Assisted Living Residents. R2's record lacked a 14-day and 90-day assessment. R3 had an admission date of April 4, 2022. R3's record lacked written acknowledgement of receipt of the Minnesota Bill of Rights for Assisted Living Residents. R3's record lacked a 14-day and 90-day assessment.	02240		

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02240	Continued From page 24 R4 had an admission date of May 24, 2022. R4's record lacked written acknowledgement of receipt of the Minnesota Bill of Rights for Assisted Living Residents. R4's record lacked a 14-day and 90-day assessment. R5 had an admission date of April 25, 2022. R5's record lacked written acknowledgement of receipt of the Minnesota Bill of Rights for Assisted Living Residents. R5's record lacked a 14-day and 90-day assessment. On August 15, 2022, at 2:00 p.m., LALD-D stated all residents had received a copy of the BOR as included in policy. However, there was not a BOR in the residents files and the resident's stated they did not receive a copy. The licensee's undated policy titled Assisted Living Bill of Rights indicated the licensee would obtain written acknowledgement that the resident received the bill of rights. The licensee's policy titled Nursing Assessment and Reassessment of Residents undated, indicated the facility will conduct a nursing assessment prior to the date on which a resident executes a contract, a reassessment no more than 14 calendar days after initiating services, and on-going assessment not to exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *08/15/22*
Time: 11:00:44
Report: 1029221246

Food and Beverage Establishment Inspection Report

Location:
Passionate Health Care Service
1555 Christie Place
St Paul, MN55106
Ramsey County, 62

Establishment Info:
ID #: N040642
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

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

EMPLOYEE ILLNESS LOG NOT PRESENT. ILLNESS LOG EMAILED TO OPERATOR.

Comply By: 08/22/22

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

MULTIPLE ITEMS IN REFRIGERATOR MEASURED ABOVE 41°F. ITEMS DISCARDED. OPERATOR ADJUSTED REFRIGERATOR TO REDUCE THE TEMPERATURE TO 41°F OF BELOW. INSTRUCTED OPERATOR TO NOT PUT ANY ADDITIONAL TCS ITEMS IN REFRIGERATOR UNTIL 41°F IS VERIFIED.

Comply By: 08/15/22

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.

OPEN PACKAGED SALAD MIX NOT DATE MARKED. NO ONE KNEW WHEN THE PACKAGE HAD BEEN OPENED. ITEM DISCARDED. INSTRUCTED OPERATOR TO IMPLEMENT DATE

MARKING WITH THIS TYPE OF PRODUCT.
Comply By: 08/15/22

4-300 Equipment Numbers and Capacities
4-302.12B ***** Priority 2 *****
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
SMALL DIAMETER PROBE NOT PRESENT. INSTRUCTED OPERATOR TO OBTAIN SMALL DIAMETER PROBE.
Comply By: 08/22/22

3-300C Protection from Contamination: equipment/utensils, consumers
3-305.11A
MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.
LARGE BOX OF CUP O' NOODLE STORED IN GARAGE ON CARDBOARD DIRECTLY ON CEMENT FLOOR. INSTRUCTED OPERATOR TO ELEVATE FOOD AT LEAST 6". OPERATOR UNPACKAGED PRODUCT AND MOVED INSIDE TO AN ELEVATED AREA.
Comply By: 08/15/22

4-200 Equipment Design and Construction
4-204.112A
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
NO INTERNAL THERMOMETERS IN REFRIGERATOR TO VERIFY TEMPERATURE. PROVIDED OPERATOR WITH 2 INTERNAL THERMOMETERS DURING THE INSPECTION.
Comply By: 08/15/22

6-300 Physical Facility Numbers and Capacities
6-301.14A
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands
HANDWASHING SIGNS NOT PRESENT IN BATHROOM. INSTRUCTED OPERATOR TO POST HANDWASHING REMINDER SIGNS AT ANY LOCATION WHERE A FOOD SERVICE WORKER WASHES THEIR HANDS.
Comply By: 08/22/22

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 47 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Food and Beverage Establishment Inspection Report

Process/Item: CHOCOLATE MILK
Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Process/Item: SHELL EGGS
Temperature: 51 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH AN HRD SURVEY AT PASSIONATE HEALTH CARE SERVICES, LOCATED AT 1555 CHRISTIE PLACE, ST. PAUL, MN 55106.

THE INSPECTION WAS CONDUCTED IN THE PRESENCE OF NGUNGE ALEMKA ANTONGAWOA, RN, LALD, & CFPM, AS WELL AS OTHER STAFF. ALL ISSUES WERE DISCUSSED WITH NGUNGE AND/OR OTHER STAFF DURING AND AFTER THE INSPECTION. EMPLOYEE ILLNESS REPORTING AND EXCLUSION PROCEDURES WERE ALSO DISCUSSED. ALL ISSUES WERE COMMUNICATED TO LEAD HRD SURVEYOR, YOLANDA DAWSON, MSN, RN, SPECIAL INVESTIGATOR, FOLLOWING THE INSPECTION.

KITCHEN HAS TILE FLOORS, LAMINATE COUNTERTOPS, WOOD/WOOD COMPOSITE CABINETRY WITH NON-ABSORBENT SURFACES, SMOOTH PAINTED WALLS, AND A SMOOTH PAINTED CEILING DIRECTLY ABOVE THE KITCHEN AREA. DAMAGE OBSERVED ON THE LOWEST DRAWER NEXT TO THE DISHWASHING MACHINE. SAMSUNG DISHWASHER SANITIZES IN ACCORDANCE WITH NSF/ANSI STANDARD 184 FOR RESIDENTIAL DISHWASHERS. KITCHEN IS IN GOOD CONDITION EXCLUDING THE BROKEN DRAWER.

THE IMPORTANCE OF COLD HOLDING, HANDWASHING, AND DATE MARKING WAS EMPHASIZED. SOFT-COOKED UNPASTEURIZED EGGS ARE NOT OFFERED TO RESIDENTS. EMPLOYEE ILLNESS LOG, VOMIT CLEANUP POSTER, HANDWASHING REMINDER SIGNS, DATE MARKING INFO SHEET, HAND CONTAMINATION INFO SHEET, AND HIGHLY SUSCEPTIBLE POPULATION INFO SHEET EMAILED TO NGUNGE.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029221246 of 08/15/22.

Certified Food Protection Manager: NGUNGE ALEMKA…

Certification Number: FM108871 Expires: 12/05/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

NGUNGE ALEMKA
ANTONGAWOA
RN, LALD

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029221246

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	4	Date	08/15/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:00:44
Legal Authority MN Rules Chapter 4626		Time Out	

Passionate Health Care Service	Address: 1555 Christie Place	City/State: St Paul, MN	Zip Code: 55106	Telephone
License/Permit #: N040642	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status					COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	IN	(OUT)			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	(OUT)			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status					COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	IN	(OUT)	N/A		Proper cold holding temperatures		
23	IN	(OUT)	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39	X	Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/21/22

Inspector (Signature)