Electronically Delivered

December 12, 2024

Licensee
Shekky Care Services Professional Corporation
1160 Chicago Avenue
St Paul Park, MN 55071

RE: Project Number(s) SL40287015

Dear Licensee:

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 survey on November 6, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

Per 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 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.

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 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
	40287	A. BUILDING: _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEKKY CARE SERVICES PROFESSIONAL C(	1160 CHICAGO AVENUE ST PAUL PARK, MN 55071

(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 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: SL40287015-0 On November 4, 2024, through November 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one resident; one receiving services under the provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
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: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 1 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 5, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all	0 620		

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0 620	Continued From page 2 cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time	0 620		

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0 620	Continued From page 3 believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1). 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: R1's diagnoses included bipolar disorder and a history of alcohol abuse. R1's Service Plan signed on January 21, 2024, indicated R1 received services including assistance with medication administration and	0 620		

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0 620	Continued From page 4 assistance with activities of daily living. An incident report, dated April 6, 2024 at 12:00 p.m., indicated that on April 5, 2024, at "about" 1:30 p.m., R1 left the assisted living, and stated he would be back by 9:00 p.m. The report further indicated at 10:00 p.m., "R1 called the assisted living and briefly hung up. Staff called back the number and no one picked up the phone. Staff drove around to look for him and he was no where to be found." The report further indicated on April 6, 2024, at approximately 7:30 a.m., licensee employees drove to downtown St. Paul, and were unable to locate R1, and at 8:30 a.m., the licensee called the police, and filed a missing person report for R1. The report did not document when R1 returned to the facility. On November 5, 2024, at 12:00 p.m., registered nurse (RN)-B stated she updated the guardian, physician, and case manager regarding the April 5, 2024, incident and was not aware she should have filed a MAARC report. RN-B stated R1 will sign out when he is leaving the assisted living, and will usually call when he needs a ride back to the assisted living. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated December 2, 2023, verified "if the Assisted Living Director or Clinical Nurse Supervisor confirms the suspicion of maltreatment, they will contact the Minnesota Adult Abuse Reporting Center (MAARC). Such report must be made no later than 24 hours after the maltreatment was first suspected." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 620		

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0 620	Continued From page 5 days	0 620		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) to include individualized interventions of the specific measures to be taken to minimize the risk of abuse, for one of one resident (R1). 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:	0 630		

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0 630	Continued From page 6 R1's diagnoses included bipolar disorder and a history of alcohol abuse. R1's Service Plan signed on January 21, 2024, indicated R1 received services including assistance with medication administration and assistance with activities of daily living. R1's Individual Abuse Prevention Plan, dated February 1, 2024, listed multiple areas of vulnerabilities which included: risk of wandering/elopement; unsafe smoking; alcohol, chemical, and/or other medication abuse; finances; and abusing other vulnerable adults. The form lacked individualized interventions and goals and outcomes specific to R1 based on the registered nurse (RN) assessments. On November 5, 2024, at 12:00 p.m., RN-B verified the IAPP lacked individualized interventions for R1. RN-B stated she and ULP-A were the primary employees who worked with R1, and would monitor and provide safety reminders to R1. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated December 2, 2023, verified the licensee would develop an "individualized vulnerable adult abuse prevention plan to identify vulnerability risks and develop measures to minimize maltreatment based on identified information." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 680	Continued From page 7	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 (EP) plan with all the required content. 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	0 680		

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0 680	Continued From page 8 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan, dated December 2, 2023, lacked customization to the facility with following content and/or policies and procedures to address: -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; -a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response use of volunteers, including the process/role for integration -arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents -a communication plan that included contact information for the following: -Federal, State, tribal, regional & local EP staff -State Licensing and Certification Agency -MN Office of Ombudsman for LTC -Participation in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; On November 5, 2024, at 12:00 p.m., registered nurse (RN)-B stated she completed the	0 680		

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0 680	Continued From page 9 emergency plan, but acknowledged she was unsure of all requirements, and completed the plan to the best of her ability. The licensee's Orientation & Training policy, dated December 2, 2023, "all assisted living facilities must have disaster planning and emergency preparedness plan," and would include the above content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	0 780		

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0 780	Continued From page 10 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability 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, 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 November 5, 2024, from 9:55 a.m. to 12:30 p.m., the surveyor toured the facility with registered nurse (RN)-B, the surveyor asked RN-B to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: 1. Resident room, basement, battery smoke alarm was not interconnected.	0 780		

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0 780	Continued From page 11 2. Common area, basement, battery smoke alarm was not interconnected. 3. Resident room, main level, battery smoke alarm was missing. 4. Resident room, main level, battery smoke alarm was not interconnected. 5. Resident room, main level, battery smoke alarm was not interconnected. 6. Common area, hallway, battery smoke alarm was not interconnected. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. These deficient conditions were visually verified by RN-B, accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=D	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.	0 800		

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0 800	Continued From page 12 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 affect a limited number of 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On November 5, 2024, from 9:55 a.m. to 12:30 p.m., the surveyor toured the facility with registered nurse (RN)-B. The surveyor made the following observations of facility hazards and disrepair: The roof soffit had a large hole in the rear of the house on the East side. The surveyor explained to RN-B that holes and gaps in the outside finish materials can serve as access points to pests and rodents. On November 5, 2024, at 11:30 a.m., RN-B stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40287	A. BUILDING: _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEKKY CARE SERVICES PROFESSIONAL C(	1160 CHICAGO AVENUE ST PAUL PARK, MN 55071

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0 810	Continued From page 13	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to 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:	0 810		

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	40287	A. BUILDING: _____ B. WING _____	11/06/2024

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0 810	Continued From page 14 Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan (FSEP) with the required content and provide the 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 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 a facility tour with registered nurse (RN)-B, on November 5, 2024, from 9:55 a.m. to 12:30 p.m., the surveyor observed the FSEP did not include room identifiers. Fire evacuation diagrams did not include the identification of the resident room numbers. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On November 5, 2024, during a facility tour from approximately 9:55 a.m. to 12:30 p.m., the surveyor observed the FSEP was not located in a central location for all staff accessibility. On November 5, 2024, RN-B provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. DRILLS:	0 810		

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	40287	A. BUILDING: _____ B. WING _____	11/06/2024

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0 810	Continued From page 15 The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, showed drills being conducted on the 15th of every month. All logs were either day or afternoon shift. No documentation was provided for night shift despite being included in the FSEP. RN-B stated that they would conduct training in November and December on the 15th to meet yearly requirements. Then follow the FSEP starting in January of 2025. On November 5, 2024, at 11:30 a.m., RN-B stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your	0 950		

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0 950	Continued From page 16 guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for one of one resident (R1). 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: R1's Service Plan signed on January 21, 2024, indicated R1 received services including assistance with medication administration and assistance with activities of daily living. R1's Assisted Living Contract was signed by R1's representative on March 26, 2024.	0 950		

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0 950	Continued From page 17 R1's assisted living contract included the statute statement from 144.50 subd. 3 with required verbatim 'right to designate a representative for certain purposes' on a separate page in the contract, but lacked documentation R1 was provided the right to name a representative or refuse to name a designated representative. On November 5, 2024, at 12:00 p.m., registered nurse (RN)-B stated she was not aware of the requirement to name or decline to name a designated representative, and include the documention in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30	01440		

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01440	Continued From page 18 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure 30-day direct observation of unlicensed personnel (ULP) performing a delegated task was documented for one of two employees (ULP-A). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired January 31, 2024, and provided direct cares to licensee residents. ULP-A's employee record lacked evidence of a 30-day supervision to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On November 5, 2024, at 12:00 p.m., registered nurse (RN)-B stated she had not completed a 30-day supervision for ULP-A. RN-B stated she completed all training, but didn't realize she	01440		

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01440	Continued From page 19 needed to complete a 30-day supervision for ULP-A. The licensee's Staff Supervision Policy, dated February 1, 2024, indicated the registered nurse will supervise "unlicensed staff (e.g., DSPs) in the delivery of personal care and support services, ensuring that tasks are performed in accordance with care plans and regulations." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

DEPARTMENT OF HEALTH

Type: Full
Date: *11/05/24*
Time: 13:45:57
Report: 1036241238

Food and Beverage Establishment Inspection Report

Location:
SHEKKY CARE SERVICES PROFESSIO
1160 CHICAGO AVENUE
St Paul Park, MN55071
Washington County, 82

Establishment Info:
ID #: 0043795
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

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.

NO EMPLOYEE ILLNESS LOG ON SITE. EXAMPLE MDH ILLNESS LOG SENT TO ESTABLISHMENT ALONG WITH REPORT.

Comply By: 11/26/24

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

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

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

OBSERVED EGGS STORED OVER RTE FOODS IN THE FRIDGE. EGGS WERE MOVED TO BOTTOM SHELF. ISSUE CORRECTED ON SITE.

Corrected on Site

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.

BRATS AND MILK IN THE FRIDGE HAD A TEMP OF 43 DEGREES F. ADVISED TO DISCARD ANY TCS FOODS THAT HAVE BEEN OPENED AND OVER 41 DEGREES F AND MONITOR TEMPERATURES. ISSUE CORRECTED ON SITE.

Corrected on Site

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE FRIDGE HAD AN AMBIENT TEMP OF 44 DEGREES F. TEMPERATURE WAS ADJUSTED ON SITE TO A TEMP OF 41 DEGREES F. ISSUE CORRECTED ON SITE.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

OBSERVED CRUMBS/RESIDUAL FOOD DEBRIS IN SOME DRAWERS AND CUPBOARDS THROUGHOUT THE KITCHEN. ADVISED TO CLEAN AT A GREATER FREQUENCY TO PREVENT SUCH ACCUMULATION.

Comply By: 11/26/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 44 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: Yes

Process/Item: Ambient Temp
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE-ADJUSTED
Violation Issued: No

Process/Item: Cold Hold/BRATS
Temperature: 43 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: Yes

Process/Item: Cold Hold/MILK
Temperature: 43 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: Yes

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

Type: Full
Date: *11/05/24*
Time: 13:45:57
Report: 1036241238
SHEKKY CARE SERVICES PROFESSIO

Food and Beverage Establishment Inspection Report

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS JOLENE BERTELSEN. INSPECTION CONDUCTED IN PRESENCE OF ELIZABETH BANJO, THE PERSON IN CHARGE. AT TIME OF INSPECTION, ESTABLISHMENT HAD ONE RESIDENT.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036241238 of 11/05/24.

Certified Food Protection Manager OLUGBENGA O. BANJO

Certification Number: FM120168 Expires: 11/27/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
ELIZABETH BANJO
PERSON IN CHARGE

Signed: _____
Jeff Johanson