Electronically Delivered

October 23, 2024

Licensee
Calm Home Health Care LLC
6901 Bethia Lane
Brooklyn Center, MN 55428

RE: Project Number(s) SL37068015

Dear Licensee:

On October 1, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 16, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

Electronically Delivered

August 8, 2024

Licensee
Calm Home Health Care LLC
6901 Bethia Lane
Brooklyn Center, MN 55428

RE: Project Number(s) SL37068015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 16, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessica Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 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
	37068	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALM HOME HEALTH CARE LLC	6901 BETHIA LANE BROOKLYN CENTER, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37068015 On July 15, 2024, through, July 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R3.) 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: R3's diagnoses include bipolar disorder (extreme mood swings, extreme excitement episodes or extreme depressive feelings,) attention-deficit/hyperactivity disorder (inattention/hyperactivity,) substance abuse disorder, schizo-affective disorder (mental health disorder that is marked by a combination of	0 630		

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0 630	Continued From page 2 schizophrenia symptoms, such as hallucinations or delusions and mood disorder, such as depression or mania,) and PTSD (post-traumatic stress disorder/mental health disorder that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations.) R3's service plan dated March 27, 2024, indicated R3 received services which included behavior management/verbal aggression, symptom management/auditory hallucinations, delusions, depression, paranoia, visual hallucinations, wandering, and medication administration five times daily. On July 15, 2024, at 2:05 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R3's medication. R3's Individual Abuse Prevention Plan dated August 29, 2023, included: -is not at risk to be abused -denied any self-injury. R3's IAPP did not include a review of the resident's risk of abusing other vulnerable adults. On July 16, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-C, registered nurse (RN)-B, and licensed assisted living director/RN (LALD/RN)-A reviewed R3's IAPP and all stated R3's record did not include the risk of abusing others. LALD/RN-A reviewed other assessments completed for R3 and said she was not able to find the question above listed in any of R3's assessments. On July 16, 2024, at 10:33 a.m., LALD/RN-A	0 630		

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0 630	Continued From page 3 stated the question of R3's susceptibility to be abused by other individuals, including other vulnerable adults was not selected for R3 on the computer system used. The licensee's Individual Abuse Prevention policy dated August 1, 2021, noted the plan would contain an individualized review or assessment of the person' susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	0 650		

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0 650	Continued From page 4 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for one of two employees (clinical nurse supervisor (CNS)-C). 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: CNS-C was hired on October 1, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On July 15, 2024, at 10:24 a.m., during the entrance conference, CNS-C identified himself as the CNS for the facility. CNS-C's employee record did not include all required documentation to include:	0 650		

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0 650	Continued From page 5 -documentation of annual performance reviews that identify areas of improvement needed and training needs. On July 15, 2024, at 3:04 p.m., agent/unlicensed personnel (A/ULP)-E stated he was not able to locate an annual performance review for CNS-C. A/ULP-E, registered nurse (RN)-B, nor licensed assisted living director/RN (LALD/RN)-A were able to locate an annual performance review in CNS-C's record. A/ULP-E stated CNS-C said a performance review had been completed for him (CNS-C). The licensee's Employee Records policy dated August 1, 2021, noted employee records for each person would include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 6 Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on July 16, 2024, from 1:00 p.m. to 2:00 p.m., with agent/ unlicensed personnel (A/ULP)-E and owner (O)-F, the surveyor made the following observations of facility disrepair: The smoke alarm in resident sleeping room 8 was beeping intermittently indicating a weak battery or maintenance required. The exhaust vent was disconnected allowing moist warm air and lint into the living space from the clothes dryer. The outside vent was disconnected from the dryer vent duct in the basement and located under the back steps making it unable to be observed for proper operation or cleaned. The clothes dryer exhaust is required to be vented to route the moist warm air containing lint to the exterior. The light fixture cover was missing from the ceiling light at the bottom of the basement stairs.	0 800		

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0 800	Continued From page 7 During a facility tour on July 16, 2024, at 1:55 p.m., A/ULP-E and O-F, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (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	0 810		

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0 810	Continued From page 8 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 July 16, 2024, at 12:35 p.m., registered nurse (RN)-B, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated August 1, 2021, failed to include the following: The FSEP did not identify specific fire protection actions for residents as evident by not providing procedures required of residents in the event of a	0 810		

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0 810	Continued From page 9 fire or similar emergency in writing in the plan. During an interview on July 16, 2024, at 1:00 p.m., RN-B, they would add the FSEP resident procedures required during a fire or similar emergency to the plan in writing. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 820		

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0 820	Continued From page 10 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on July 16, 2024, from 1:00 p.m. to 2:00 p.m. with agent/ unlicensed personnel (A/ULP)-E and owner (O)-F, the following distinct hazards were observed: There was used cigarette butts discarded on the wood steps and landing at the back door leading out of the kitchen to the patio. There was an appropriate metal cigarette butt container provided at the back patio/ designated smoking area location. These deficient conditions were visually verified by A/ULP-E, and O-F, accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	01060		

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01060	Continued From page 11 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the	01060		

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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
01060	Continued From page 12 emergency relocation within four days 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 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's diagnosis included substance use, hallucinations (symptoms and fear of being assaulted,) depression, anxiety, and schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions and mood disorder, such as depression or mania.) R1's record included: Weekly Progress Notes, dated March 13, 2024, authenticated by clinical nurse supervisor (CNS)-C: "Name (R1) has been presenting sever (sic) hallucinations, delusions, paranoid and fear of being attacked symptoms. R1 had recently multiple ER (emergency room) visit for the same symptoms. R1 received his Invaga injection (schizoaffective disorder/paranoia) on March 6, 2024. All his medication for the week has been set up and reviewed, and all of his vital signs are normal. I've (CNS-C) instructed the staff to contact the registered nurse should they have any needs or concerns. We (facility) will continue to monitor him as necessary. R1 is scheduled for	01060		

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	37068	A. BUILDING: _____ B. WING _____	07/16/2024

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01060	Continued From page 13 appointment with his psychiatrist on April 1st, 2024." Progress Note, dated March 21, 2024, authenticated by CNS-C: "Name (R1) has been experiencing severe hallucinations, delusions, paranoia, and fear of being attacked. He has visited the emergency room multiple times in the past two weeks for the same symptoms. On March 20, 2024, he (R1) was admitted to the hospital's mental health unit due to his instability. He will be transferred to the mental health crisis unit as an inpatient." R1's record included Discharge Summary completed April 25, 2024: -reason for discharge/transfer, specify: (name/R1) continues with his delusional thinking at North Memorial Hospital. He (R1) has been found positive for several different drugs over several different days at the hospital. R1 does not take part in any hospital groups/activities and sleeps most of the day in the hospital. He (R1) will be transferred to a CBHH (community behavioral health hospital) from North Memorial per his (R1) case manager. R1's record lacked a written notice that contained, at a minimum: -the name and contact information for the location to which the resident had been relocated and any new service provider; -contact information for the OOLTC; -known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

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01060	Continued From page 14 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On July 15, 2024, at 12:05 p.m., registered nurse (RN)-B stated she "thought" the hospital would send something out, adding "we" (licensee) worked closely with R1's case manager. CNS-C stated he was not aware of the requirement. The licensee's Emergency Relocation policy dated August 1, 2021, noted in the event of an emergency relocation, (facility name) would provide a written notice that contained, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident had been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. If known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known, and e. A statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal. The facility would provide contact information for the agency to which the resident may submit an appeal. The notice required would be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and	01060		

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01060	Continued From page 15 community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	01640		

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01640	Continued From page 16 Based on observation, interview, and record review, the licensee failed to ensure one of two residents (R2) service plans was revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses include attention-deficit/hyperactivity disorder (inattention/hyperactivity,) schizo-affective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions and mood disorder, such as depression or mania,) and generalized anxiety disorder. R2's service plan dated March 19, 2024, indicated R2 received services which included behavior management, medication administration two times daily, blood pressure daily, oxygen saturation daily, pulse daily, temperature daily, and weights one day a week. R2's prescriber order dated May 2, 2024, included: -glucose blood, test BG (blood glucose) one time daily. On July 16, 2024, at 7:55 a.m., the surveyor observed unlicensed personal (ULP)-D place a	01640		

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01640	Continued From page 17 testing strip into a blood glucose meter, ready a pen lancet (small needle used to puncture skin,) and gather two alcohol pads. On July 16, 2024, at 7:58 a.m., the surveyor observed ULP-D collect R3's blood glucose reading on 97 using correct technique. R2's service detail active, dated May 4, 2024, included record blood glucose- AM (morning) daily. -wearing gloves and following agency procedure, check blood glucose and record. Staff to check BG every morning before breakfast. Notify RN if: If blood glucose is less than 70 or greater than 300. R2's service plan did not include blood glucose monitoring. On July 16, 2024, at 9:49 a.m., registered nurse (RN)-B stated R2's blood glucose monitoring was new, "two months." RN-B showed the surveyor the updated service plan in the computer system used, which was not authenticated by R2 or by R2's representative, which included blood glucose monitoring. RN-B stated the service plan the surveyor was given was "old," and pointed out the date of the service plan (March 2024). RN-B confirmed R2's service plan had not been updated as required to include blood glucose monitoring. The licensee's Service Plan policy dated August 1, 2021, noted a service plan means the written plan between a resident or resident's designated representative and the facility about the services that would be provided to the resident. The service plan and any revisions shall include a signature or other authentication by (name of	01640		

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01640	Continued From page 18 facility) and by the resident, or resident's representative, documenting agreement on the services to be provided. Service plans and any revisions or updates shall be entered into the resident's record, including notice of change in fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee, (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a	01760		

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01760	Continued From page 19 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 15, 2024, at 1:56 p.m., the surveyor observed ULP-D log onto a computer, review R2's medication administration record (MAR), remove amphetamine salts (attention-deficit/hyperactive) 30 milligram (mg) and clonazepam (anxiety disorder) 0.5 mg from a locked medication box, and put these medications into a medication cup. ULP-D added the medication from a bubble pack of medications into the medication cup. On July 15, 2024, at 1:59 p.m., ULP-D reviewed the MAR and marked each medication verified, administered, and then hit a green key (which indicated the administration was complete). On July 15, 2024, at 2:00 p.m., ULP-D took a bottle of water and a medication cup of medication to R2. ULP-D administered R2's medication. On July 15, 2024, at 2:02 p.m., ULP-D stated "hey (name/R3), it is medication time." ULP-D reviewed R3's MAR, placed buspone (anxiety)15 mg, and propranolol (anxiety) 20 mg into a medication cup. ULP-D marked each medication verified, administered, and hit the green button. On July 15, 2024, at 2:05 p.m., ULP-D administered R3's medication.	01760		

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01760	Continued From page 20 On July 15, 2024, at 2:07 p.m., ULP-D stated the green button was "complete." ULP-D said it was easier that way (medication administration) adding they (licensee) might lose information also if medications were documented differently. ULP-D stated the residents don't refuse their medications, "they (residents) are good about taking medications." ULP-D said he could easily correct the MAR if medication administration did not occur. On July 15, 2024, at 2:16 p.m., clinical nurse supervisor (CNS)-C stated he was afraid they (licensee) may lose information, "black screen"' so staff/ULPs document (medication administration) when screen (computer) is up (open). Licensed assisted living director/registered nurse (LALD/RN)-A stated marking medication administered prior to administration was not the expectation. LALD/RN-A said ULPs should give medication, then document medication was given. LALD/RN-A confirmed documentation of medication was not performed as required. The licensee's Medication Management-Administration & Setup policy dated August 1, 2021, noted the nursing staff and unlicensed personnel trained to provide medication administration at (name of facility) would document any medication administration provided accurately in each resident record. Documentation of medication administration would be completed immediately after that task had been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 21 days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to make certain medications requiring refrigeration were maintained at acceptable temperatures for one of one medication refrigerator. 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 July 15, 2024, at 11:09 a.m., clinical nurse specialist (CNS)-C stated the current temperature of the medication refrigerator was 35 degrees Fahrenheit (F). CNS-C said the refrigerator should be 34 degrees to 40 "something" degrees. The content of the medication refrigerator was reviewed with CNS-C and confirmed the following: -two unopened Wegovy (weight loss) pens for	01880		

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01880	Continued From page 22 R3. Directly after the review of the medication refrigerator, CNS-C stated the refrigerator was new and in use for a "couple of weeks." CNS-C stated the temperature of the medication refrigerator was not monitored. Agent/unlicensed personnel (A/ULP)-E stated they (licensee) do monitor the food refrigerator's temperature and added they (licensee) could add the medication refrigerator monitoring into the computer system used. CNS-C questioned if R3's Wegovy required to be kept between 36-46 degrees F. CNS-C removed the manufacturer's insert from the box and commented, yes, 36-46 degrees was required. The manufacturer's directions for Wegovy dated May 2024, noted: store Wegovy pen in the refrigerator from 36 degrees F to 46 degrees F. If needed, before removing the pen cap, Wegovy can be stored from 46 degrees to 86 degrees F in the original carton for up to 28 days. Do not freeze. Throw away pen if Wegovy has been frozen, has been exposed to light or temperatures above 86 degrees F, or has been out of the refrigerator for 28 days or longer. The licensee's Medication Storage policy dated August 1, 2021, noted medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen.) No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01910	Continued From page 23	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. 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	01910		

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01910	Continued From page 24 situation has occurred only occasionally). The findings include: R1's diagnosis included substance use, hallucinations (symptoms and fear of being assaulted,) depression, anxiety, and schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions and mood disorder, such as depression or mania.) R1's service plan dated February 5, 2024, indicated R1 received medication administration two times daily, and monthly. R1's medication disposition dated April 1, 2024, to April 25, 2024, included: -haloperidol (mood disorders/psychosis) five milligrams (mg), disposed 105 -melatonin (sleep) three milligrams, disposed 81 -Suboxone (opioid dependence/addiction) eight mg-two mg, disposed 89 -Tab-a Vite (supplement), disposed 73 -trazodone (anti-depressant), disposed 29 -Zyprexa (agitation) 15 mg, disposed 58 -Zyprexa, disposed 81. R1's medication administration record (MAR) dated March 1, 2024, through March 20, 2024, included: -Narcan (suspected overdose) four milligram (mg)/0.1 milliliter (ml) spray nasal, spray one spray in nostril as needed (PRN) for suspected opioid o.d. (overdose). Call 911 immediately after use. R1's prescriber order dated February 2, 2024, included the above-mentioned medication.	01910		

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01910	Continued From page 25 R1's record lacked to include a complete medication disposition/disposal record, to include Narcan. On July 15, 2024, at 2:12 p.m., R1's record was reviewed with registered nurse (RN)-B, licensed assisted living director/RN (LALD/RN)-A, and clinical nurse supervisor (CNS)-C. CNS-C, LALD/RN-A, and RN-B stated the facility would have had Narcan available for R1 and added it would have been R1's not a house stock medication. RN-B stated she completed R1's medication disposition and R1's PRN Narcan was sent with R1's other medications. RN-B said she was not sure why the Narcan was not on R1's medication disposition record. The computer system used by the licensee was contacted regarding R1's Narcan. RN-B stated the Narcan did not populate on the form as it should have, she maybe did not click on the key "hard" enough. RN-B confirmed R1's Narcan was not on R1's medication disposition record as required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. The license's Resident Record-Information and Content policy dated August 1, 2021, noted the facility (name) would maintain appropriate and accurate records for each resident that received assisted living services. No further information was provided.	01910		

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	37068	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALM HOME HEALTH CARE LLC	6901 BETHIA LANE BROOKLYN CENTER, MN 55428

(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
01910	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		

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

Type: Full
Date: *07/15/24*
Time: 13:45:00
Report: 1013241047

Food and Beverage Establishment Inspection Report

Location:
Calm Home Health Care Llc
6901 Bethia Lane
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0038588
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124339070
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Eggs
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Hot dogs
Temperature: 5 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator C. Casey.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, laminate counter top, and a smooth painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, and food handling procedures.

Type: Full
Date: *07/15/24*
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Report: 1013241047
Calm Home Health Care Llc

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 1013241047 of 07/15/24.

Certified Food Protection Manager: Hamid Abdi Mohamed

Certification Number: 117901 Expires: 06/11/26

Inspection report reviewed with person in charge and emailed.

Signed:_____
Hamid Abdi Mohamed
Operator

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us