



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 14, 2025

Licensee
Best Home Health Care Service
6044 Clinton Avenue South
Minneapolis, MN 55419

RE: Project Number(s) SL35749015

Dear Licensee:

On March 17, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 30, 2024, and the follow-up survey completed on December 17, 2024. 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,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery
February 12, 2025

Licensee
Best Home Health Care Service
6044 Clinton Avenue South
Minneapolis, MN 55419

RE: License Number 418594
Health Facility Identification Number (HFID) 35749
Project Number(s) SL35749015

Dear Licensee:

On December 17, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed December 17, 2024. Based on these findings, the condition(s) on the license were removed effective December 17, 2024.

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.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 17, 2024 initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on December 17, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

0950 - Designation Of Representative - 144g.50 Subd. 3
1640 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (a-E)
1760 - Documentation Of Administration Of Medication - 144g.71 Subd. 8 - \$500.00
1820 - Prescriptions - 144g.71 Subd. 13 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 17, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on December 17, 2024, we identified the following violation(s):

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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 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).

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

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

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Best Home Health Care Service. Please contact Bob Dehler at 651-201-3710 on or before Tuesday, February 18, 2025, to schedule the conference call.

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

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/17/2024
NAME OF PROVIDER OR SUPPLIER BEST HOME HEALTH CARE SERVICE		STREET ADDRESS, CITY, STATE, ZIP CODE 6044 CLINTON AVENUE SOUTH MINNEAPOLIS, MN 55419			
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL35749015-1 On December 16, 2024, through December 17, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 30, 2024. At the time of the survey, there were two (2) residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued or reissued.	{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.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}			

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{0 780}	Continued From page 3	{0 780}			
{0 790} SS=B	This MN Requirement is not met as evidenced by: 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:	{0 790}	Not reviewed during this survey.		
{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.	{0 800}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 800}	Continued From page 4	{0 800}			
{0 810} SS=F	This MN Requirement is not met as evidenced by: 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) staff 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) Staff 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 staff 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.	{0 810}	Not reviewed during this survey.		

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{0 810}	Continued From page 5		{0 810}		
	This MN Requirement is not met as evidenced by:			Not reviewed during this survey.	
0 820 SS=D	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 resident rooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some 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		0 820		

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0 820	Continued From page 6 of staff are involved, or the situation has occurred only occasionally). The findings include: On December 17, 2024, at 12:15 p.m. the surveyor conducted a follow-up with unlicensed personnel (ULP) - G for orders issued pursuant to a survey completed on August 27, 2024. During the tour, survey staff asked ULP-G to open the window in unoccupied resident room 2 for measurement. The surveyor observed that it appeared that the right-hand window in resident room 2 had been replaced. The right-hand window is a casement style, and the left-hand side is a double hung style. The noncompliant measurements were as follows: Resident room 2: The window measured 16 inches clear width, 33 inches clear height, and 528 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820			
{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:	{0 950}			

Minnesota Department of Health

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{0 950}	Continued From page 7 "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 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 ensure the assisted living contract included the designation of representative statutory language. This had the potential to affect all residents who lived in the licensee's facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	{0 950}			

Minnesota Department of Health

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{0 950}	Continued From page 8 or has potential to affect a large portion or all of the residents). The findings include: On December 16, 2024, at 11:35 a.m., licensed assisted living director (LALD)-A provided a designated representative contract example dated October 23, 2024, and stated the example was the licensee's contract language used for each resident. The example provided lacked the required verbatim language. On December 16, 2024, at 12:56 p.m., LALD-A contacted contracted consultant who worked with the licensee to review designated representative verbatim language. LALD-A stated consultant had provided the contract and was not sure why the required language was missing. On December 16, 2024, at 1:35 p.m., LALD-A stated consultant had provided an addendum to licensee assisted living contract with the required verbatim language, but licensee had failed to provide the addendum to the residents. LALD-A stated licensee had multiple addendums for the assisted living contract and licensee missed adding it to the contracts when licensee had residents sign the assisted living contract. LALD-A stated each resident would be provided with the addendum and the addendum will be added to each resident's assisted living contract. No further information provided.	{0 950}			
{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	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 9 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: Based on interview and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided 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:	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 10 The Application for Assisted Living License submitted May 18, 2021, by licensed assisted living director (LALD)-A indicated the licensee applied for an initial license. R3 was admitted on December 1, 2022. R3's Service Plan - Waiver with effective date December 26, 2022, was identified by LALD-A as R3's most current authenticated service plan and read, "The Assisted Living provides services under MN (Minnesota) Comprehensive Home Care License." The service place indicated R3 received the following home care items: - Home Care Services and Fee Schedule; - Minnesota Home Care Bill of Rights, and; - Statement of Home Care Services. On December 16, 2024, at 11:55 a.m., LALD-A stated licensee had not provided R3 with an updated service plan to accurately reflect licensee was not a home care provider. LALD-A stated R3's service plan was outdated and had incorrect information for home care licensing when licensee was assisted living licensed. LALD-A stated licensee would need to generate a current service plan for R3 from the electronic health record and obtain authentication from the appropriate parties. The licensee's 6.08 Service Plan policy dated September 1, 2024, indicated a service plan would identify the assisted living services agreed upon and authenticated by the licensee and the resident. No further information provided.	{01640}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/17/2024
NAME OF PROVIDER OR SUPPLIER BEST HOME HEALTH CARE SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 6044 CLINTON AVENUE SOUTH MINNEAPOLIS, MN 55419		
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{01760}	Continued From page 11	{01760}			
{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 interview and record review, the licensee failed to ensure each medication administered by the assisted living facility was documented in the record and when not administered as prescribed, documentation included the reason why and follow-up procedures that were provided to meet the resident's needs for two of two residents (R2, 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 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).	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 12 The findings include: R2 R2 was admitted on April 18, 2024. R2's Service Plan (Waiver) - Addendum to Contract with effective date October 21, 2024, indicated R2 received medication administration and medication setup. R2's Med Admin Summary - Actual - Month dated December 2024, indicated with red colored circles R2 did not receive medication administration at different times on the following days: December 1, 3, 5, 7, 9, 10, and 13, 2024. At the bottom of the document in red color print, each medication missed was documented a reason R2's medications were not administered. No follow up was documented by staff or a registered nurse as to steps taken to prevent or assess the impact of the missed medication administration times. R3 R3 was admitted on December 1, 2022. R3's Service Plan - Waiver with effective date December 26, 2022, indicated R3 received medication management services. R3's Med Admin Summary - Actual - Month dated December 2024, indicated with red colored circles R3 did not receive medication administration at different times on the following days: December 2, 3, 8, and 10. Additionally, no documentation was noted on December 6, 2024, for the bedtime administration of R3's Gabapentin (an antiseizure and nerve pain medication) 400 mg (milligrams) take 2 capsules every evening.	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 13 On December 16, 2024, at 12:20 p.m., licensed practical nurse (LPN)-C stated times when meds were circled red were when the resident either refused or was out of the facility and staff did not administer the medications as ordered by the resident's primary care provider. LPN-C stated date when R3 had no documentation should have documentation if the medication was declined or not administered for a reason. LPN-C stated staff were learning the newly implemented electronic health record and still required additional training to ensure all aspects of medication administration including nursing follow up when a medication was not administered was documented. The licensee's 7.08 Medication Management - Administration & Setup policy dated September 1, 2024, indicated all medication administration would be documented immediately after the task was performed and all medications not administered as ordered would include documentation of the reason and follow-up procedures. No further information provided.	{01760}			
{01820} SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of	{01820}			

Minnesota Department of Health

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{01820}	Continued From page 14 two residents (R2, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on April 18, 2024. R2's Service Plan (Waiver) - Addendum to Contract with effective date October 21, 2024, indicated R2 received medication administration and medication setup. R2's Med Admin Summary - Actual - Month dated December 2024, indicated R2 received 17 unique medications administered by the licensee. R2's record lacked evidence of authenticated provider orders for medications administered. R3 R3 was admitted on December 1, 2022. R3's Service Plan - Waiver with effective date December 26, 2022, indicated R3 received medication management services. R3's Med Admin Summary - Actual - Month dated December 2024, indicated R3 received four (4) unique medications administered by the licensee.	{01820}			

Minnesota Department of Health

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{01820}	Continued From page 15 R3's record lacked evidence of authenticated provider orders for medications administered. On December 16, 2024, at 12:05 p.m., surveyor requested a copy of authenticated orders for each administered medication for R2 and R3. On December 16, 2024, at 12:35 p.m., licensed practical nurse (LPN)-B stated the licensee relied on the pharmacy to provide orders for each resident. LPN-B stated providers would send the pharmacy the orders and then the pharmacy would send the medications to the licensee. LPN-B stated licensee could call pharmacy to obtain signed orders for all medications, but licensee did not have a copy of signed orders for all medications administered by licensee. The licensee's 7.20 Medication & Treatment Orders policy dated September 1, 2024, indicated current orders would be obtained and maintained for all medications administered to residents by the licensee. No further information provided.	{01820}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 4, 2024

Licensee
Best Home Health Care Service
6044 Clinton Avenue South
Minneapolis, MN 55419

RE: Conditional License Number 414422
Health Facility Identification Number (HFID) 35749
Project Number(s) SL35749015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 30, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **January 02, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,000.00. **MDH is not imposing these fines against your license at this time.**

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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>

CONDITIONAL LICENSE ISSUED:

MDH will issue Best Home Health Care Service a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Best Home Health Care Service is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Best Home Health Care Service will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Best Home Health Care Service must provide the Department:
 - i. A list of the names and birthdates of any individuals Best Home Health Care Service is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Best Home Health Care Service will contract with an RN to provide consultation concerning all resident(s) to whom Best Home Health Care Service provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Best Home Health Care Service. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Best Home Health Care Service and MDH must review the RN’s credentials and approve the selection. Best Home Health Care Service is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Best Home Health Care Service in an effort to help Best Home Health Care Service align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Best Home Health Care Service will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

- d. Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Best Home Health Care Service and the RN consultant about a change. Each report will be electronically submitted to Jess Schoenecker, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at jess.schoenecker@state.mn.us. Jess Schoenecker can be reached at 651-201-3789 (office) with questions about reports. The content of the reports will include information such as:

 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Best Home Health Care Service to correct the violations cited during the survey as well as to determine the overall practice of Best Home Health Care Service in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. Corrective Action Plan:** Best Home Health Care Service will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern

- iii. A target date for when each correction will be complete
- iv. Who is responsible to make sure it happens
- v. Current status of correction work
- vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Best Home Health Care Service is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Best Home Health Care Service is in substantial compliance on the follow up survey, MDH will remove the conditions from Best Home Health Care Service's assisted living facility license, and Best Home Health Care Service will correct any outstanding violations identified during the survey. If Best Home Health Care Service is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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 Jess Schoenecker directly at: 651-201-3789.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

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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: SL# 35749015-0 On August 26, 2024 through, August 30, 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 2 resident(s); 2 receiving services under the provider's Assisted Living Facility license. On August 27, 2024, an immediate correction order was issued for tag identification 0820 and 2310. On August 29, 2024, the immediacy of the order for tag identification 0820 was removed, but noncompliance remained, and the scope/level remain unchanged. The immediacy of order 2310 was not removed at the time of survey exit on August 30, 2024.	0 000			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that the licensed assisted living director (LALD) was registered with the Minnesota Board of Executives for Long Term Services and Supports (BELTSS) as the licensee's Director of Record. This had the potential to affect all the licensee's residents, staff, and visitors. 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 the potential to affect a large portion or all the residents). The findings include: LALD-A was hired August 1, 2021, and began providing assisted living services. On August 22, 2024, at 3:10 p.m., the Minnesota BELTSS website was reviewed, and LALD-A was the Director of Record for the facility with an end date of October 31, 2023. On August 26, 2024, at approximately 1:30 p.m.,	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 LALD-A stated they thought they were listed as the Director of Record for the facility and had recently received an email from BELTSS (renewal email) and would update the website with Director of Record information. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 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: During the entrance conference on August 26, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated they were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat.	0 250			

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0 250	Continued From page 5 chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.	0 250			

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0 250	Continued From page 6 - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-A on May 18, 2021. An Assisted Living License was granted to licensee effective August 1, 2021, with an expiration date of July 31, 2022. As a result of this survey, the following orders were issued: 0110, 0250, 0470, 0480, 0550, 0630, 0660, 0680, 0780, 0790, 0800, 0810, 0950, 1370, 1380, 1440, 1470, 1530, 1620, 1640, 1700, 1730, 1760, 1770, 1820, 1880, 1910, 1940, 1970, and 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not	0 250			

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0 250	Continued From page 7 evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470			

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0 470	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement a staffing plan to determine staffing levels to meet the needs of all residents and failed to evaluate that plan at least twice a year. Additionally, the licensee failed to ensure the 24-hour staffing schedule was posted as required, potentially affecting all the licensee's current 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 the residents). The findings include: On August 26, 2024, at approximately 1:15 p.m., the surveyor observed that a daily staffing schedule was not posted in the common area. On August 26, 2024, at approximately 1:30 p.m., the surveyor requested a staffing plan and 24-hour schedule and licensed assisted living director (LALD)-A stated they did not have a schedule or staffing plan as they are a small facility, and the information was "in their head." On August 27, 2024, at approximately 10:00 a.m., the surveyor observed an undated weekly staffing schedule posted in the common area. On August 27, 2024, at approximately 10:15 a.m.,	0 470			

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0 470	Continued From page 9 surveyor requested the staffing plan and LALD-A stated they did not have one and thought they had met the requirement by posting the weekly staffing schedule. On August 30, 2024, surveyor received an email from LALD-A which included an undated Staffing Planning document lacking staffing metrics to determine appropriate staffing levels and evidence the plan had been reviewed twice per year. The licensee's 4.06 Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan and indicated the daily 24-hour staffing plan would be posted. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
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 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.	0 480			

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0 480	Continued From page 10 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 August 26, 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			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility	0 550			

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0 550	Continued From page 11 Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the facility's' grievance procedure, the name, telephone number, and e-mail contact information for the individuals responsible for handling resident grievances, 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 information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). 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 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 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 clients). The findings include: On August 26, 2024, at approximately 11:00 a.m., the surveyor observed that the licensee lacked a posting of facility's grievance procedure in a conspicuous place to include the following information: -name, phone number and email contact information for the individuals who were responsible for handling resident complaints;	0 550			

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0 550	Continued From page 12 -contact information for the state and any regional Office of Ombudsman for Long-Term-Care; -contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; -contact information for the MAARC; and -contact information for the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH). On August 26, 2024, at approximately 11:00 a.m., licensed assisted living director (LALD)-A stated they were unaware of the requirements for posting the grievance process. On August 27, 2024, at approximately 10:00 a.m., the surveyor observed the licensee's grievance process was posted, but lacked the following information: -name, phone number and email contact information for the individuals who were responsible for handling resident complaints; -contact information for the state and any regional Office of Ombudsman for Long-Term-Care; -contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; -contact information for the MAARC; and -contact information for the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH). On August 28, 2024, at approximately 9:30 a.m., the surveyor observed the facility's grievance process was posted in a central area with all required content. The licensee's undated Complaint and Investigation Process policy did not address posting the facility's grievance process in a common area.	0 550			

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0 550	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=F	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 an individual abuse prevention plan (IAPP) with the required content for two of two residents (R1, R2). 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 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:	0 630			

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0 630	Continued From page 14 R1 R1 was admitted on January 9, 2024, and began receiving assisted living services. R1's Service Plan Waiver dated January 15, 2024, indicated R1's services included assistance with dressing and grooming, medication administration, and behavior management. R1's IAPP dated April 29, 2024, lacked information on the resident's risk of causing harm to other vulnerable adults. R2 R2 was admitted on April 22, 2024, and began receiving assisted living services. R2's Service Plan Waiver dated April 22, 2024, indicated R2's services included assistance with bathing and tube feedings, medication administration, and behavior management. R2's IAPP dated August 16, 2024, lacked information on the resident's risk of causing harm to other vulnerable adults. On August 27, 2024, at approximately 11:04 a.m., clinical nurse supervisor (CNS)-B stated they were unaware of required content of IAPPs and would update the R-Task system (online medical record system) to capture the required information. The licensee's undated Abuse Prevention Plan policy read "all residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the	0 630			

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0 630	Continued From page 15 specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. This includes self-abuse. The plan will be incorporated into the resident care plan and will reflect their ability to participate in and direct their own care in the presence of an identified caregiver." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for	0 660			

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0 660	Continued From page 16 Disease Control and Prevention (CDC); failed to ensure history and symptoms screening and a test for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed prior to performing resident care for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's Facility TB Risk Assessment Worksheet was completed on December 20, 2023, and lacked an indication of risk level for TB transmission. ULP-E was hired on January 18, 2024, and began providing assisted living services. ULP-E's employee record included a QuantiFERON-TB Gold test dated January 25, 2024, with negative results. ULP-E's employee record lacked a TB symptom screen and history. On August 28, 2024, at approximately 9:00 a.m., licensed assisted living director (LALD)-A stated a TB symptom screen and history was not completed on ULP-E and that one would be completed.	0 660			

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0 660	Continued From page 17 The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated "an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's undated Tuberculosis Screening policy read "each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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;	0 680			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 18 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents of the assisted living licensee. 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: The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: -annual review and update; -development of a hazard vulnerability	0 680			

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0 680	Continued From page 19 assessment, taking an all-hazards approach; -identification of at-risk population needs including independence, communication, transportation, supervision, and medical care; -delegation of authority; -process for emergency preparedness collaboration with local, tribal, regional, State and Federal emergency preparedness; - policies addressing subsistence needs for staff and residents such as food, water, medical supplies and pharmaceutical supplies; - procedures for tracking of staff and patients; - policies and procedures for evacuation of residents and staff; - policies and procedures for the use of volunteers; - policies and procedures for medical documents to address preservation of resident information, protection of confidentiality, and secures/maintains the availability of records; -arrangements with other facilities; -roles under a waiver declared by secretary; -quarterly review of missing resident plan. - development of a written communication plan which must include: -names and contact information; -emergency officials contact information; - primary and alternative means for communication; - methods for sharing information on occupancy and needs; and - long-term care (LTC) family notifications; and -exercises to test the emergency plan at least twice per year including unannounced staff drills using the EPP. On August 28, 2024, at approximately 1:30 p.m., licensed assisted living director (LALD)-A stated they were not aware of all the requirements of Appendix Z. LALD-A stated they had not updated	0 680			

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0 680	Continued From page 20 their emergency preparedness plan for several years. The licensee's undated Emergency Management Policy indicated the facility would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. 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 21 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 are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. 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) 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 August 27, 2024, from approximately, 12:45 p.m. to 2:15 p.m., survey staff toured the home accompanied by the licensed assisted living director (LALD)-A from 12:45 p.m. to 2:00 p.m. and the unlicensed personnel (ULP)-D joined at approximately, 1:45 p.m. to 2:15 p.m. During the tour, survey staff observed, that the smoke alarms were not interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout as required. The deficient finding was evident when inside resident sleeping room 3 and the lower-level hallway, the smoke alarms were tested, and each smoke alarm sounded local. The ULP-D verbally verified the finding and stated that each alarm sounds	0 780			

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0 780	Continued From page 22 independent. Survey staff observed that the home had multiple brands of hardwired and battery-operated smoke alarms. Survey staff explained that the different brands of smoke alarms may not be compatible with the interconnection of smoke alarms, and they need to replace or reach out to the manufacturer for guidance for proper installation so that when one alarm is activated, all smoke alarms in the world operate and sound (interconnected) throughout the home. The above deficient findings were verified by the ULP-D and the LALD-A at the time of discovery accompanying the home tour. On August 27, 2024, at approximately 4:00 p.m., survey staff explained the above deficient findings to the LALD-A and the ULP-D during the exit interview. The LALD-A and the ULP-D understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=B	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	0 790			

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0 790	Continued From page 23 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 maintain the portable fire extinguisher. This had the potential to directly affect residents and staff. 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 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 27, 2024, from approximately, 12:45 p.m. to 2:15 p.m., survey staff toured the home accompanied by the licensed assisted living director (LALD)-A from 12:45 p.m. to 2:00 p.m. and the unlicensed personnel (ULP)-D joined at approximately, 1:45 p.m. to 2:15 p.m. During the tour, survey staff observed the mounted PE unit in the kitchen had no monthly inspection records. The tag was not attached to this PE unit but was located near the unit. Review of the tag indicated no written inspection records or other logs available for review to show the unit had monthly inspections at the time of discovery. The LALD-A stated they bought the unit last year and did not know about the monthly inspections.	0 790			

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0 790	Continued From page 24 During an interview, survey staff explained the deficient finding to the LALD-A, and she understood and acknowledged the finding at the time of discovery during the home tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the 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, 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	0 800			

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0 800	Continued From page 25 has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 27, 2024, from approximately, 12:45 p.m. to 2:15 p.m., survey staff toured the home accompanied by the licensed assisted living director (LALD)-A from 12:45 p.m. to 2:00 p.m. and the unlicensed personnel (ULP)-D joined at approximately, 1:45 p.m. to 2:15 p.m. During the tour, survey staff observed the following: -The licensee failed to provide proper cigarette butt receptacles in the home ' s designated smoking areas. The survey staff observed a can with cigarette butts inside. The LALD-A verified the finding and stated that their designated smoking areas are in the back and front of the house. -The main level resident sleeping room 2 had an unapproved magnetic-lock (mag-lock) door security system with exposed wires inside the room. The system requires electricity (low voltage) to open which may cause delays and impediments in exiting the room during a fire, a power outage, or similar emergency and violate state codes. Survey staff observed that the system also included a push button to release the magnetic lock from inside the room and a camera with a key-pad identification system on the outside of the room for resident (R2) and staff to identify themselves before accessing the room, and in addition, the room door also had a standard door lockset with a key to access from the exterior of the room requiring multiple actions to egress the room. The resident (R2) was present and explained that R2 installed the magnetic-lock security system for their personal	0 800			

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0 800	Continued From page 26 and work equipment security and protection, but, the system is not in use due to maintenance. R2 added that the mag-lock on the door would deactivate and fail to open if power is lost. Survey staff explained to the LALD-A that the mag-lock system is not approved for use in an assisted living home and any electrical installation including low voltage for technology systems requires a license under Minnesota Law (only a homeowner who actually occupies may perform any electrical or low voltage work). The LALD-A verified the finding and stated that the mag-lock door security system and work-related equipment inside are R2 's hobby, and the LALD-A was very concerned about communicating with the R2 about the finding. -The exhaust fan cover in the main-level bathroom was covered with thick dust. The LALD-A verified the finding at the time of discovery. -Duct tape was used inside the main bathroom behind the lavatory pedestal to cover the lavatory drain, wall area, and the air duct outlet diffuser behind the pedestal. The LALD-A confirmed the finding and stated they had a plumbing leak at one time so they used duct tape temporarily, but the leak was fixed and had not removed the duct tape. -The pedestal lavatory plumbing fixtures in the main- and lower-level bathrooms were loose and partially detached from the wall. The LALD-A and the ULP-D acknowledged the findings and asked survey staff about how to secure the fixtures to the wall. -The gas and water meter control valves were located inside the resident sleeping room 3 on the	0 800			

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0 800	Continued From page 27 lower-level floor, preventing immediate and staff-ready access to the control valves during an emergency. Survey staff explained to the ULP-D that the control valves were located inside the resident's sleeping room limiting access. Control valves must be available to employees for ready access at all hours of the day including evening hours for emergency access. The deficient finding was verbally and visually verified by the ULP-D at the time of discovery. On August 27, 2024, at approximately 4:00 p.m., survey staff explained the above deficient findings to the LALD-A and the ULP-D during the exit interview. The LALD-A and the ULP-D understood and acknowledged the findings. No further information was provided. 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.	0 810			

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0 810	Continued From page 28 (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, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 810			

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0 810	Continued From page 29 The findings include: On August 27, 2024, from approximately, 12:45 p.m. to 2:15 p.m., survey staff toured the home accompanied by the licensed assisted living director (LALD)-A from 12:45 p.m. to 2:00 p.m. and the unlicensed personnel (ULP)-D joined at approximately, 1:45 p.m. to 2:15 p.m. During the tour, survey staff observed: -The posted fire evacuation diagram (plan) for the main floor did not include room numbers for each resident bedroom. Evacuation plans must include the location of resident sleeping room numbers. -The lower-level floor did not have a posted fire evacuation diagram (plan). In addition, the lower-level evacuation plan was not available or provided for review during an interview. The above deficient findings were visually and/or verbally verified by the LALD-A at the time of discovery. On August 27, 2024, at approximately, 2:30 p.m., document and record review and interview with the LALD-A, on the home's fire safety and evacuation plan and related training policies, procedures, and records indicated the following: -Document review indicated the licensee's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection	0 810			

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0 810	Continued From page 30 procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the LALD-A verified that the fire safety and evacuation plan did not include these provisions. -Record review of available documentation indicated that the employee training on fire safety and evacuation was incomplete. The licensee did not provide employee training on the home's fire safety and evacuation plan twice per year after the initial hire training. -Record review showed training was provided through a third-party online training for orientation and not a site-specific fire safety and evacuation plan tailored for the home's layout and conditions, and resident movements during a fire or similar emergency. During an interview, LALD-A verified that they used third-party online training, and the employee training did not include the home's site-specific fire safety and evacuation plan. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency. The LALD-A could not provide documentation showing any training offered to residents on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per shift per year with at least one evacuation drill every other month for calendar years 2202 and 2023. Record review indicated that evacuation drills were correctly conducted to date for the year 2024, but no records were available or provided for calendar years 2022 and 2023. During the interview, the LALD-A verified that they lacked evacuation drills for the previous years, 2022 and 2023.	0 810			

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0 810	Continued From page 31 The above deficient findings were verified by the LALD-A during the interview. On August 27, 2024, at approximately 4:00 p.m., survey staff explained the above deficient findings to the LALD-A and the ULP-D during the exit interview. The LALD-A understood and acknowledged the findings. No further information was provided. 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 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	0 950			

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NAME OF PROVIDER OR SUPPLIER BEST HOME HEALTH CARE SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 6044 CLINTON AVENUE SOUTH MINNEAPOLIS, MN 55419		
(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
0 950	Continued From page 32 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 the interview and record review, the licensee failed to identify a designated representative or document that the resident declined to designate a representative for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the client 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 clients). The findings include: R1 R1 was admitted on January 9, 2024, and began receiving assisted living services. R1's Service Plan Waiver dated January 15, 2024, indicated R1's services included assistance with activities of daily living (ADLs), behavior management, and medication administration. R1's contract signed January 9, 2024, included a space to designate a representative, but was marked N/A (not applicable) and not	0 950			

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0 950	Continued From page 33 authenticated by resident to decline naming a designated representative. R1's record lacked a separate designated representative notice containing the required statutory language. R2 R2 was admitted on April 18, 2024, and began receiving assisted living services. R2's Service Plan Waiver dated April 22, 2024, indicated R2's services included assistance with bathing and meal preparation, medication administration, and behavior management. R2's contract signed April 19, 2024, included a space to designate a representative, but was marked N/A (not applicable) and not authenticated by resident to decline naming a designated representative. R1's record lacked a separate designated representative notice containing the required statutory language. On August 26, 2024, at approximately 1:15 p.m., licensed assisted living director (LALD)-A stated they were unaware of the designated representative requirements in contracts. The licensee's undated Assisted Living Contracts policy indicated the designated representative notice would be provided on a document separate from the contract. The contract would contain a space for the resident to name their designated representative, and a box for the resident to initial if they declined to name a designated representative.	0 950			

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0 950	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy;	01370			

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01370	Continued From page 35 (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training and competency testing was completed for two of two employees (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-D ULP-D was hired on March 6, 2019, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. On August 26, 2024, at 1:45 p.m., ULP-D was observed providing direct care services to R2. ULP-D's employee record lacked the following documentation of required training and competency testing to be completed by a registered nurse (RN):	01370			

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01370	Continued From page 36 -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and -awareness of commonly used health technology equipment and assistive devices. ULP-E ULP-E was hired on January 18, 2024, and began providing assisted living services. ULP-E's employee file lacked the following documentation of required training and competency testing to be completed by a RN: -procedures to utilize in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On August 29, 2024, at approximately 11:45 a.m., clinical nurse supervisor (CNS)-B stated they were unaware of missing competencies from employee files. CNS-B stated education was completed through computer training modules and he evaluated at 30-days and 90-days post hire. The licensee's undated Qualifications, Training, and Competency policy indicated training for unlicensed personnel would include the following: -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and resident's preferences, cultural background, and family; and -awareness of commonly used health technology equipment and assistive devices.	01370			

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01370	Continued From page 37 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure competency testing was completed in all required areas for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01380			

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01380	Continued From page 38 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on January 18, 2024, and began providing assisted living services. ULP-E's employee file lacked documentation of required competency testing to be completed by a RN for reading and recording temperature, pulse, and respirations of the resident. On August 29, 2024, at approximately 11:45 a.m., clinical nurse supervisor (CNS)-B stated they were unaware there was missing competency documentation in ULP-E's employee record. CNS-B stated they were responsible for training and competency testing of employees. The licensee's undated Qualifications, Training, and Competency policy indicated ULP training would include reading and recording temperature, pulse, and respirations of the resident and documentation of training/competency would be maintained in the personnel file of each employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an	01440			

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01440	Continued From page 39 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 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) supervised unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for two of two employees (ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01440			

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01440	Continued From page 40 The findings include: ULP-D ULP-D was hired March 6, 2019, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. On August 26, 2024, at approximately 2:00 p.m., ULP-D was observed administering medications and treatments to R2. ULP-D's employee file lacked documentation of direct supervision within 30 days of performing delegated tasks. ULP-E ULP-E was hired January 18, 2024, and began providing assisted living services. R2's Medication Administration Record dated August 2024, indicated ULP-E had administered medications to R2 on August 1, 2, 4, 8, 9, 11, 15, 16, 19, 22, and 23, 2024. ULP-E's employee file lacked documentation of direct supervision within 30 days of performing delegated tasks. On August 28, 2024, at approximately 11:00 a.m., licensed assisted living director (LALD)-A stated staff supervisions were to be completed by clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-C at 30-days and 90-days. LALD-A stated they thought the supervision had been completed. The licensee's undated Supervision of Unlicensed Personnel policy read " the direct	01440			

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01440	Continued From page 41 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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470			

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01470	Continued From page 42 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470			

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01470	Continued From page 43 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-D ULP-D was hired on March 6, 2019, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP-D's employee record lacked documentation of the following required orientation content: -an introduction and review of provider's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -orientation to each specific resident and services provided. ULP-E ULP-E was hired on January 18, 2024, and began providing assisted living services. ULP-E's employee record lacked documentation of the following required orientation content: -overview of assisted living statutes; -an introduction and review of provider's policies	01470			

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01470	Continued From page 44 and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of resident complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of the Ombudsman for Long-Term Care, Office of the Ombudsman of Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -orientation to each specific resident and services provided. On August 28, 2024, at approximately 11:00 a.m., licensed assisted living director (LALD)-A stated they were unaware that orientation content was incorrect, and they would notify the online computerized education company to update the assignments for employee orientation. The licensee's undated Facility Employee	01470			

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01470	Continued From page 45 Orientation policy indicated all employees would complete an orientation on topics required by Minnesota statutes and rules for assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530			

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01530	Continued From page 46 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for two of two employees (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired March 6, 2019, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. ULP-D's employee record included a My Transcript dated August 27, 2024, indicating ULP-D had completed four and a quarter (4.25) hours of dementia care training in 2021. ULP-D's employee record lacked the required 8 hours of dementia care training within 160 working hours. ULP-E ULP-E was hired January 18, 2024, and began providing assisted living services. ULP-E's employee record included a My Transcript dated August 27, 2024, indicating ULP-E had completed three and three quarters	01530			

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01530	Continued From page 47 (3.75) hours of dementia training in February 2024. ULP-D's employee record lacked the required 8 hours of dementia care training within 160 working hours. On August 28, 2024, at approximately 10:55 a.m., licensed assisted living director (LALD)-A stated ULP-D and ULP-E had not completed 8 hours on initial dementia care training. LALD-A stated they thought the dementia care training required only four hours of initial training. The licensee's undated Dementia Care Training policy indicated direct care employees would have completed at least 8 hours of initial training on dementia care topics in the 160 hours from employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620			

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01620	Continued From page 48 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure nursing assessments and reassessments were conducted by the registered nurse (RN) for two of two residents (R1, R2) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 was admitted on January 9, 2024, and began receiving assisted living services. R1's Service Plan Waiver signed January 15, 2024, indicated R1's services included assistance with dressing, meal reminders, behavior management, and medication administration.	01620			

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01620	Continued From page 49 R1's record included a 90-day assessment completed April 29, 2024, by licensed practical nurse (LPN)-C. R2 R2 was admitted on April 18, 2024, and began receiving assisted living services. R2's Service Plan Waiver dated August 22, 2024, indicated R2's services included assistance with bathing, meal preparation, medication administration, and tube feeding. R2's record included a 14-day assessment completed on May 7, 2024, by LPN-C. On August 27, 2024, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A stated they were unaware assessments and reassessments were required to be completed by the RN. Minnesota Rule 4659.0140 Subpart 4.A. reads "a registered nurse shall complete nursing assessments and reassessments required under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c). No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
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.	01640			

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01640	Continued From page 50 (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: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on April 18, 2024, and began	01640			

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01640	Continued From page 51 receiving assisted living services. R2's diagnoses include type I diabetes, eating disorder, bipolar disorder, and anxiety. On August 26, 2024, at approximately 1:45 p.m., the surveyor observed unlicensed personnel (ULP)-D provide wound care to R2. On August 26, 2024, at approximately 2:15 p.m., the surveyor observed ULP-D apply a continuous glucose monitor and an insulin pump to R2. On August 27, 2024, at approximately 10:00 a.m., the surveyor observed a cardiac monitor in R2's room at the bedside. R2 stated she was monitored at night and data was transmitted to an outside company and to a monitor to the office on-site for staff to monitor for alerts. On August 28, 2024, at approximately 9:45 a.m., the surveyor observed ULP-D assist R2 with setting up and starting a tube feeding via a Kangaroo feeding pump (a programmable pump that delivers continuous or intermittent tube feedings). R2's Service Plan Waiver dated April 22, 2024, indicated R2's services included tube feeding as needed. The service plan lacked continuous glucose monitoring application, insulin pump application, and cardiac monitoring services. On August 29, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated R2's service plan lacked services for continuous glucose monitoring application, insulin pump application, and cardiac monitoring services as she was "independent with those things".	01640			

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01640	Continued From page 52 The licensee's undated Service Plan policy indicated service plans would include a description of services provided and would be based on assessment and resident preference and is consistent with accepted standards of practice for professional nursing or other relevant standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent	01700			

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01700	Continued From page 53 diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a medication management assessment which included all content prior to providing medication management services for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on January 9, 2024, and began receiving assisted living services. R1's Service Plan Waiver signed January 15, 2024, indicated R1's services included medication administration. R1's Medication Administration Record dated April 2024, indicated medications that had been administered to R1 included duloxetine (to treat depression), gabapentin (to treat seizures), olanzapine (to treat bipolar depression and schizophrenia), and nortriptyline (an	01700			

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01700	Continued From page 54 antidepressant). R1's medication assessment completed by clinical nurse supervisor (CNS)-B on January 14, 2024, lacked the following required content: -identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and -interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. R2 R2 was admitted on April 18, 2024, and began receiving assisted living services. R2's Service Plan Waiver signed on April 22, 2024, indicated R2's services included medication set-up and medication administration. R2's Medication Administration Record dated August 2024, indicated medications that had been administered to R2 included spironolactone (diuretic), Breo Ellipta Inhaler (to treat asthma), doxazosin (to treat high blood pressure), gabapentin (to treat nerve pain), erythromycin (an antibiotic), Linzess (to treat constipation), estradiol patches (estrogen supplement), levetiracetam (to treat seizures), metoprolol (heart medication), and naltrexone (for anxiety).	01700			

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01700	Continued From page 55 R2's medication assessment completed by CNS-B on April 23, 2024, lacked the following required content: -identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and -interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. On August 27, 2024, at approximately 11:00 a.m., CNS-B stated they were unaware of the required content for medication management assessments. CNS-B stated, "just tell me what is missing, and I will fix it". The licensee's undated Medication Management Services policy did not address medication management assessments. The licensee's undated Individual Medication Management Plan policy did not address medication management assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			

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01730	Continued From page 56	01730			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730			

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01730	Continued From page 57 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a medication management plan prior to starting medication management services and failed to maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R2) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 was admitted on January 9, 2024, and began receiving assisted living services. R1's Service Plan Waiver signed January 15, 2024, indicated R1's services included medication administration. R1's Individualized Medication Management Plan dated April 29, 2024, and signed by licensed practical nurse (LPN)-C on August 28, 2024 (during survey process) lacked the following required content: -description of storage of medications based on	01730			

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01730	Continued From page 58 the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's recommendations; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R2 R2 was admitted on April 18, 2024, and began receiving assisted living services. R2's Service Plan Waiver dated April 22, 2024, indicated R2's services included medication set-up and medication administration. R2's Individualized Medication Management Plan printed on August 27, 2024, lacked the following required content: -description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's recommendations; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when	01730			

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01730	Continued From page 59 a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On August 26, 2024, at approximately 1:45 p.m., unlicensed personnel (ULP)-D was observed administering medications to R2. On August 27, 2024, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-B stated they were unaware of the requirements of medication management plans for residents. CNS-B stated, "just tell me what is missing, and I will fix it". The licensee's undated Individualized Medication Management Plan and Record policy indicated the facility would develop and individualized medication management plan and record based on the nursing assessment and the needs or preferences of the resident. The policy also indicated the Individualized Medication Management Plan would be modified when necessary and modified plans would be signed by the resident or resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760			

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01760	Continued From page 60 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 each medication administered by the assisted living facility was documented in the record and when not administered as prescribed, documentation included the reason why and follow-up procedures that were provided to meet the resident's needs for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on April 18, 2024, and began receiving assisted living services.	01760			

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NAME OF PROVIDER OR SUPPLIER BEST HOME HEALTH CARE SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 6044 CLINTON AVENUE SOUTH MINNEAPOLIS, MN 55419		
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01760	Continued From page 61 R2's Service Plan Waiver signed on April 22, 2024, indicated that R2's services included medication administration. R2's Medication Administration Record (MAR) dated August 2024, included but was not limited to the following medications: -spironolactone 25 milligram (mg) tablets, take 1 tablet by mouth (PO) every evening (for blood pressure); -Breo Ellipta 100 microgram (mcg)/25 mcg inhaler, inhale 1 puff every evening (for asthma); -lamotrigine 200 mg tablet, take one tablet PO at bedtime (for bipolar disorder); -gabapentin solution 250 mg/5 milliliter (ml), take 6 ml PO three times daily (for pain); -loperamide 2 mg capsules; take 2 capsules PO after the first stool. Then take 1 capsule after each subsequent stool. Take no more than 2 capsules in 24 hours. -Linzess 290 mcg capsule, take PO once daily (for constipation); -Omnipod DASH insulin management system pods, place one on skin every 48 hours. -FIASP Insulin 100 units (u)/ml, use in insulin pump up to 100 u/day. Inject 200 units into Omnipod every 48 hours (for diabetes); -aripiprazole 20 mg tablet, take 1 tablet PO once daily (antipsychotic); -estradiol 0.1 mg patch, Apply 2 patches topically to skin every Monday and apply 3 patches topically to skin every Thursday to total 5 patches per week.; -levetiracem 100 mg/ml solution, take 5 ml PO twice daily (for seizures); -metoprolol 25 mg, take 1 tablet twice daily, okay to crush for administration (for blood pressure); -doxazosin 2 mg tablets, take 1 tablet PO at bedtime (for nightmares); -erythromycin 250 mg tablet take 1 tablet PO	01760			

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01760	Continued From page 62 three times daily for 7 days then hold for 7 days, then repeat (for infection); -hydroxyzine 50 mg tablets, take 1 tablet PO three times daily as needed (for anxiety); and -scopolamine 1 mg patch, apply 1 patch behind ear every 3 days as needed. On August 26, 2024, at approximately 1:45 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medication to R2 via jejunostomy tube (J-tube). R2 stated she did not take medications orally and all medications were administered through the J-tube. On August 26, 2024, at approximately 2:30 p.m., the surveyor observed ULP-D draw up insulin from a vial and fill R2's Omnipod insulin pump and apply the pump to R2's upper right arm. R2 stated a new Omnipod was filled with insulin and applied every two days. R2 stated she was able to fill and apply her insulin pump but preferred the assistance of staff due to her visual impairment. On August 28, 2024, at approximately 9:30 a.m., the surveyor observed ULP-D assist R2 with setting up and administering a feeding via J-tube. R2's MAR dated August 2024, lacked specific routes and instructions for medication administration via J-tube. The MAR also lacked documentation for tube feeding administration. R2's MAR dated August 2024, lacked documentation of administration including the reason why and follow up procedures that were provided for the following medications: -lamotrigine 200 mg tablet, take one tablet PO at bedtime (for bipolar disorder); -Omnipod DASH insulin management system pods, place one on skin every 48 hours.	01760			

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01760	Continued From page 63 -FIASP Insulin 100 u/ml, use in insulin pump up to 100 u/day. Inject 200 units into Omnipod every 48 hours (for diabetes); and -aripiprazole 20 mg tablet, take 1 tablet PO once daily (antipsychotic). On August 28, 2024, at approximately 10:30 a.m., licensed assisted living director (LALD)-A stated R2's insulin was not documented on the MAR as her Individualized Medication Management Plan indicated she was independent with her insulin management. On August 29, 2024, at approximately 1:15 p.m., clinical nurse supervisor (CNS)-B stated he was unaware that medication administration documentation was not completed and was not sure if medications were given as ordered. CNS-B also stated he was unaware tube feedings were included in medication management if staff were assisting R2 with tube feedings. The licensee's undated Documentation of Medication Administration policy read "each medication administered by the assisted living facility staff will be documented in the resident's record. The documentation will include the signature and title of the person who administered the medication. Documentation will include the medication name, dosage, date and time administered, and method and route of administration. Staff will 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." No further information was provided.	01760			

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01760	Continued From page 64	01760			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 was admitted January 9, 2024, and began receiving assisted living services. R1's Service Plan Waiver signed January 15, 2024, indicated R1's services included medication administration.	01770			

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01770	Continued From page 65 R2 R2 was admitted on April 18, 2024, and began receiving assisted living services. R2's Service Plan Waiver signed April 22, 2024, indicated R2's services included medication setup and medication administration. On August 26, 2024, at approximately 1:45 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medication to R2 that had been previously set up in a pillbox. On August 28, 2024, at approximately 11:50 a.m., licensed practical nurse (LPN)-C stated he set up resident medications weekly into pillboxes for ULPs to administer. LPN-C stated he compared medications to the medication administration record but did not document the setting up of medication. LPN-C stated he would develop a system to document medication setup in the future. The licensee's undated Medication Set Up policy did not address documentation at the time of medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is	01820			

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01820	Continued From page 66 managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on January 9, 2024, and began receiving assisted living services. R1's Service Plan Waiver signed January 15, 2024, indicated R2's services included medication administration. R1's Medication Administration Record (MAR) dated April 2024, indicated R1 was administered the following medications: -duloxetine 30 milligram (mg) capsule, take one (1) by mouth (PO) every morning (antidepressant); -gabapentin 300 mg capsule, take two (2) capsules PO four (4) times daily (for seizures; was discontinued on April 11, 2024); -olanzapine 5 mg tablet, take 1-2 tablets PO at bedtime (for schizophrenia);	01820			

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01820	Continued From page 67 -nortriptyline 10 mg capsule, take 1 capsule PO at bedtime (antidepressant); and -gabapentin 400 mg capsules, take 2 capsules PO four times daily (for seizures). R1's record lacked signed provider orders for the following medications: -duloxetine 30 mg capsule, take 1 capsule PO every morning (antidepressant); -nortriptyline 10 mg capsule, take 1 capsule PO at bedtime (antidepressant); and -gabapentin 40 0mg capsules, take 2 capsules PO four times daily (for seizures). R2 R2 was admitted on April 18, 2024, and began receiving assisted living services. R2's Service Plan Waiver dated April 22, 2024, indicated R2's services included medication set-up and medication administration. R2's Medication Administration Summary for August 2024, indicated R2 was administered the following medications: -spironolactone 25 mg tablets, take 1 tablet PO every evening (for blood pressure); -Breo Ellipta 100 microgram (mcg)/25 mcg inhaler, inhale 1 puff every evening (for asthma); -lamotrigine 200 mg tablet, Take one tablet PO at bedtime (for bi-polar disorder); -gabapentin solution 250 mg/5 milliliter (ml), take 6 ml PO three times daily (for pain); -linzess 290 mcg capsule, take PO once daily (for constipation); -Fiasp Insulin 100 unit (u)/ml use in insulin pump up to 100 u/day. Inject 200 units into Omnipod every 48 hours (for diabetes); -aripiprazole 20 mg tablet, take 1 tablet PO once daily (antipsychotic);	01820			

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01820	Continued From page 68 -estradiol 0.1 mg patch. Apply 2 patches topically to skin every Monday and apply 3 patches topically to skin every Thursday to total 5 patches per week.; -levetiracem 100 mg/ml solution, take 5 ml PO twice daily (for seizures); -metoprolol 25 mg, take 1 tablet twice daily, okay to crush for administration (for blood pressure); -doxazosin 2 mg tablets, take 1 tablet PO at bedtime (for nightmares); -erythromycin 250 mg tablet take 1 tablet PO three times daily for 7 days then hold for 7 days, then repeat (for infection); -hydroxyzine 50 mg tablets, take 1 tablet PO three times daily as needed (for anxiety); and -scopolamine 1 mg patch, apply 1 patch behind ear every 3 days as needed. R2's record lacked signed provider orders for the following medications: -linzess 290 mcg capsule, take 1 capsule PO once daily (for constipation); -aripiprazole 20 mg tablet, take 1 tablet PO once daily (antipsychotic); -doxazosin 2 mg tablets, take 1 tablet PO at bedtime (for nightmares); and -scopolamine 1 mg patch, apply 1 patch behind ear every 3 days as needed. On August 28, 2024, at approximately 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R2 with administering a tube feeding via J-tube (a feeding tube inserted through the abdomen into the small intestine). R2's record lacked signed provider orders for tube feedings. On August 28, 2024, at approximately 9:40 a.m., licensed assisted living director (LALD)-A stated they did not have all prescriptions for R1 as he	01820			

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01820	Continued From page 69 sometimes used a different pharmacy and would pick up his medications independently. LALD-A stated she did not know how the nurse knew to transcribe the medications on to the MAR. On August 29, 2024, at approximately 12:45 p.m., clinical nurse supervisor (CNS)-B stated staff were trained to assist R2 with tube feedings at her direction as she likes to "try different things". CNS-B also stated they were unaware of missing prescriptions for R2. The licensee's undated Medication Prescriptions and Refills policy indicated a current written prescriber's prescription must be obtained for any medication, including over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication, or providing other medication management services for a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
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 store all prescription medications in securely locked and substantially	01880			

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01880	Continued From page 70 constructed compartments according to the manufacturer's directions. 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: On August 28, 2024, at approximately 11:00 a.m., surveyor observed a small, unlocked refrigerator in the unlocked office. The refrigerator contained four (4) unopened boxes of FIASP Insulin (a fast-acting insulin) and one open, unlabeled vial of FIASP insulin. The refrigerator also contained a bottle of Gabapentin solution. The refrigerator lacked a thermometer and documentation the refrigerator temperature was monitored. On August 26, 2024, at approximately 1:30 p.m., licensed assisted living director (LALD)-A stated they kept sensitive documents at another office off site as the office in the facility was accessible to all staff. On August 28, 2024, at approximately 11:00 a.m., licensed assisted living director (LALD)-A stated the refrigerator was not locked or monitored for temperature. LALD-A stated she was unable to locate a locked refrigerator. The FIASP package insert developed by Novo Nordisk Inc., and dated June 2023, indicated the following storage instructions: -Unused FIASP vials should be stored between	01880			

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01880	Continued From page 71 2° to 8° Celsius (C) (36° to 46° Fahrenheit (F)) in a refrigerator but not in or near a freezing compartment. - FIASP should not be exposed to excessive heat or light and must never be frozen. Do not use FIASP if it has been frozen. - FIASP should not be drawn into a syringe and stored for later use. The Neurontin (gabapentin) package insert distributed by Parke Davis pharmaceuticals and revised July 2010, indicated gabapentin solution should be refrigerated at 2° to 8° C (36° to 46°F). The licensee's undated Medication Management Services policy indicated the registered nurse (RN) would develop specific procedures for controlling and storing medications including controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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	01910			

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01910	Continued From page 72 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 the disposition of the medications in the resident's record, 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 was admitted on January 9, 2024, and discharged on May 4, 2024, (per R1's unsigned, undated Discharge Summary). On August 27, 2024, at approximately 12:30 p.m., licensed assisted living director (LALD)-A provided surveyor with an undated and unsigned Medication Inventory Record and stated it was R1's medication disposition record. The Medication Inventory record lacked the following required content:	01910			

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01910	Continued From page 73 -documentation of to whom the medications were given; -date of disposition; and -names of staff and other individuals involved in the disposition. On August 27, 2024, at approximately 12:30 p.m., LALD-A stated R1 self-discharged on May 2, 2024, and they notified the case manager. LALD-A stated case manager told her it was okay to give medications to resident, who returned "a couple of days later" and picked up medications. On August 28, 2024, at approximately 10:05 a.m., LALD-A stated that R1 had signed the Medication Inventory form, and she did not know where it was located. As of survey close on August 30, 2024, at approximately 4:00 p.m., the signed Medication Inventory form and not been provided to surveyor. The licensee's undated Medication Disposition or Disposal policy indicated that medication disposition included staff documentation in the resident record the name of the person to whom the medications were given, the time and date, the name of each medication, dose, and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	01940			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER BEST HOME HEALTH CARE SERVICE		STREET ADDRESS, CITY, STATE, ZIP CODE 6044 CLINTON AVENUE SOUTH MINNEAPOLIS, MN 55419			
(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
01940	Continued From page 74 ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER BEST HOME HEALTH CARE SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 6044 CLINTON AVENUE SOUTH MINNEAPOLIS, MN 55419		
(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
01940	Continued From page 75 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on April 18, 2024, and began receiving assisted living services. R2's Service Plan dated August 5, 2022, indicated R2 received services including tube feedings as needed (PRN). On August 26, 2024, at approximately 1:45 p.m., the surveyor observed wound care being provided to R2 by unlicensed personnel (ULP)-D. On August 26, 2024, at approximately 2:15 p.m., the surveyor observed ULP-D apply a continuous blood glucose monitor and insulin pump to R2. On August 27, 2024, at approximately 10:00 a.m., the surveyor observed a cardiac monitor in R2's room and R2 stated she was monitored at night with data transmitted to a separate monitor in the office for staff to observe and respond to alarms. On August 28, 2024, at approximately 9:30 a.m., the surveyor observed ULP-D assisting R2 with setting up and initiating a tube feeding. R2's record lacked a treatment or therapy management plan with all required content. On August 29, 2024, at approximately 11:45 a.m., clinical nurse supervisor (CNS)-B stated they	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2024
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01940	Continued From page 76 were unaware a treatment plan was required and stated R2 was "mostly independent" with her care. The licensee's undated Treatment and Therapy Management Plan policy indicated an individualized treatment/therapy plan would be developed to include the following content: -a written statement of the treatment or therapy that will be provided; -documentation of specific instructions that relate to providing the treatment or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services; -any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented; -frequency of supervision of personnel providing the delegated treatment or therapy services; -verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions; -the treatment or therapy plan will be updated when there are changes; and -the facility may provide care plans one other supportive documents to communicate the plan to caregivers by refencing them on the individualized plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2024
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01970	Continued From page 77	01970			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on April 18, 2024, and began receiving assisted living services. R2's Service Plan dated August 5, 2022, indicated R2 received services including medication administration, assistance with activities of daily living (ADLs), meal preparation, and tube feedings as needed (PRN).	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2024
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01970	Continued From page 78 On August 26, 2024, at approximately 1:45 p.m., the surveyor observed wound care being provided to R2 by unlicensed personnel (ULP)-D. On August 26, 2024, at approximately 2:15 p.m., the surveyor observed ULP-D apply a continuous blood glucose monitor and insulin pump to R2. On August 27, 2024, at approximately 10:00 a.m., the surveyor observed a cardiac monitor in R2's room and R2 stated she was monitored at night with data transmitted to a separate monitor in the office for staff to observe and respond to alarms. On August 28, 2024, at approximately 9:30 a.m., the surveyor observed ULP-D assisting R2 with setting up and initiating a tube feeding. R2's record lacked a current signed order for wound care, continuous glucose monitor application, insulin pump application, cardiac monitoring parameters, and tube feeding. On August 29, 2024, at approximately 11:45 a.m., clinical nurse supervisor (CNS)-B stated they were unaware that prescriber orders were required for wound care, continuous glucose monitoring application, insulin pump application, tuber feeding, and cardiac monitoring/parameters as R2 was "mostly independent" with those cares. The licensee's undated Treatment and Therapy Management Plan policy indicated treatments and therapies would be administered by facility staff only as ordered by the physician or designated prescriber. No further information was provided.	01970			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2024
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01970	Continued From page 79	01970			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R2) with bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include : R2 was admitted on April 22, 2024, and began receiving assisted living services. R2 ' s diagnoses included type 1 diabetes, eating disorder, and bipolar depression. R2's 90-day assessment dated August 16, 2024,	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2024
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02310	Continued From page 80 indicated R2 had bed rails but lacked an individualized assessment for the bed rail use. R2 ' s medical record lacked the following: -an individualized bed rail assessment; -documentation of measurements of zones of entrapment; and -documentation of discussion of the risk and benefits with R2 and/or R2's responsible party. On August 27, 2024, at approximately 11:00 a.m., the surveyor asked licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, and licensed practical nurse (LPN)-C about R2's hospital style bed with upper bed rails. LALD-A and LPN-C stated an assessment was not required as the bed was not ordered by a physician but was requested by the resident. LALD-A stated the hospital bed had belonged to a former resident and was given to R2 per the resident ' s request. CNS-B stated a bedrail assessment had not been completed. On August 27, 2024, at approximately 11:10 a.m., the surveyor observed a hospital bed in R2 ' s room with quarter bed rails on both sides near the head of bed. On August 27, 2024, at approximately 11:15 a.m., the surveyor shared the Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQs) website with the licensee via email. The FDA's A Guide to Bed Safety, revised April 2010, indicated the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2024
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02310	Continued From page 81 with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The MDH Assisted Living: Resources and FAQs website dated April 3, 2024, indicated an individualized bed rail assessment should include: "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." The website further stated the following documentation should be included in a resident ' s record regarding bed rails: · "Purpose and intention of the bed rail · Measurements · The resident's bed rail use/need assessment · Risk vs. benefits discussion (individualized to each resident's risks) · The resident's preferences · Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation · Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's undated Use of Side Rails policy	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2024
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02310	Continued From page 82 indicated the registered nurse (RN) would assess and evaluate what the resident ' s needs were and if the resident could safely utilize the bed rail/equipment. The assessment would determine whether the equipment meets the FDA standards for bed rails. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of order 2310 was not removed at the time of survey exit on August 30, 2024.	02310			

Type: Follow-Up
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Food and Beverage Establishment Inspection Report

Page 1

Location:

Best Home Health Care Service
6044 Clinton Avenue South
Minneapolis, MN55419
Hennepin County, 27

Establishment Info:

ID #: 0038373
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6129909616
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 previously issued on 08/26/24 have NOT been corrected.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CFPM. CFPM CERTIFICATE ATTAINMENT INSTRUCTIONS PROVIDED TO OPERATOR.

9/19/24: STAFF IN TRAINING CLASS.

Issued on: 08/26/24

Comply By: 09/27/24

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

ESTABLISHMENT USING UNLABELED SPRAY BOTTLE OF ALCOHOL FOR SURFACE SANITIZER. REP INDICATED THEY WOULD SWITCH TO PREPACKAGED WIPES TO SANITIZE SURFACES.

Comply By: 09/19/24

Food and Equipment Temperatures

Process/Item: COLD HOLD/KETCHUP

Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR DOOR (NON TCS)

Violation Issued: No

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

ESTABLISHMENT INSTALLED CRITERION HIGH TEMP DISHWASHER TO SANITIZE UTENSILS AND EQUIPMENT. MANUFACTURER’S MANUAL STATED HIGH TEMP SANITIZE REACHES 158F. TEMPRITE THERMAL STICKERS USED BY ESTABLISHMENT TO REGISTER DISHWASHER’S HIGHEST TEMP: AT LEAST 180F.

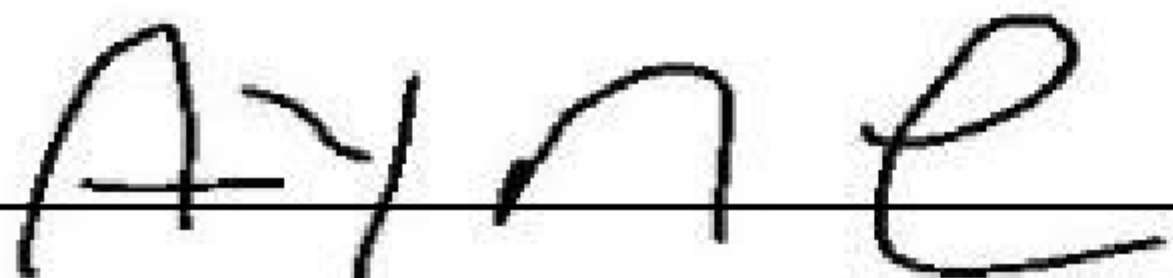
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029241326 of 09/19/24.

Certified Food Protection Manager: VACANT

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: 
AYNE ABEBE
LALD

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

Type: Full
Date: 08/26/24
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Food and Beverage Establishment Inspection Report

Page 1

Location:

Best Home Health Care Service
6044 Clinton Avenue South
Minneapolis, MN55419
Hennepin County, 27

Establishment Info:

ID #: 0038373
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6129909616
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.

NO EMPLOYEE ILLNESS LOG. ILLNESS LOG PROVIDED TO OPERATOR DURING INSPECTION. OPERATOR INSTRUCTED TO MAINTAIN EMPLOYEE ILLNESS LOG.

Comply By: 08/26/24

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.

TEMP ABUSED TCS FOODS IN REFRIGERATOR IDENTIFIED. DISCARDED BY OPERATOR. OPERATOR INSTRUCTED TO VERIFY TEMPS OF 41°F OR LESS THROUGHOUT COOLER PRIOR TO PLACING NEW TCS ITEMS INTO COOLER.

Comply By: 08/26/24

4-700 Sanitizing Equipment and Utensils

4-703.11C

**** Priority 1 ****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

FOOD CONTACT SURFACE SANITIZER NOT AT ESTABLISHMENT. REP INDICATED THEY WOULD OBTAIN SODIUM HYPOCHLORITE FOOD CONTACT SURFACE SANITIZER AND

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Food and Beverage Establishment Inspection Report

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HAND MIX SOLUTION TO SANITIZE UNTIL SANITIZING DISHWASHER IS INSTALLED. CL
OBTAINED AND SOLUTION MADE.

Comply By: 08/26/24

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.

NO SMALL DIAMETER PROBE THERMOMETER. OPERATOR INSTRUCTED TO OBTAIN SMALL
DIAMETER PROBE THERMOMETER.

Comply By: 08/30/24

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO CL TEST STRIPS. SMALL AMOUNT OF TEST STRIPS PROVIDED AND PICTURE TAKEN OF
COLOR CHART FOR CONCENTRATIONS. REP INSTRUCTED TO OBTAIN TEST STRIP SUPPLY
TO TEST SOLUTION UNTIL DISHWASHER IS INSTALLED.

Comply By: 08/26/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CFPM. CFPM CERTIFICATE ATTAINMENT INSTRUCTIONS PROVIDED TO OPERATOR.

Comply By: 09/27/24

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.

INTERNAL THERMOMETER IN REFRIGERATOR MOVED TO WARMEST PART OF COOLER. NO
INTERNAL THERMOMETER IN FREEZER. OPERATOR INSTRUCTED TO PLACE INTERNAL
THERMOMETER IN FREEZER.

Comply By: 08/26/24

4-300 Equipment Numbers and Capacities

4-301.12D

MN Rule 4626.0680D Mechanical warewashing equipment in lieu of a 3-compartment sink may be
allowed as long as the warewashing equipment is large enough to accommodate the largest piece of
equipment to be washed, rinsed and sanitized.

ESTABLISHMENT W/OUT WORKING SANITIZING DISHWASHER OR 3-COMP SINK.
REPRESENTATIVE INDICATED THEY WILL INSTALL A DISHWASHER TO SANITIZE
EQUIPMENT AND UTENSILS.

Comply By: 09/27/24

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6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
SEAL BEHIND SINK DEGRADED AND PEELED BACK, WATER DAMAGE AND MOLD UNDER SINK AREA, SMALL HOLES IN WALL. OPERATOR INSTRUCTED TO REPAIR.
Comply By: 09/27/24

Surface and Equipment Sanitizers

CHLORINE: = 75 PPM at Degrees Fahrenheit
Location: SANITIZER BOWL
Violation Issued: No

Food and Equipment Temperatures

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

Process/Item: DELI SANDWICH
Temperature: 50 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Process/Item: 1/2 & 1/2
Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

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

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		3	2	4

KITCHEN RESIDENTIAL IN NATURE. CVT FLOOR, LAMINATE COUNTERS, SMOOTH PAINTED WALLS AND CEILING, WOOD/COMPOSITE WOOD DRAWERS AND CABINETRY.

FOOD SAFETY AND FOODBORNE ILLNESS RISK FACTORS DISCUSSED WITH OPERATOR. ALL IDENTIFIED ISSUES ADDRESSED WITH OPERATOR DURING INSPECTION.

NO SANITIZING DISHWASHER OR 3-COMP SINK. 2-COMP SINK AVAILABLE. NO FOOD CONTACT SURFACE SANITIZER AT ESTABLISHMENT. LARGE BOWL AND DRYING RACK SET UP NEXT TO 2-COMP SINK. REP OBTAINED CHLORINE DURING INSPECTION AND A CHLORINE SANITIZER SOLUTION WAS MIXED TO 75 PPM. WASH, RINSE, SANITIZE, AND AIR-DRY PRACTICE DISCUSSED WITH OPERATOR.

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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 1029241254 of 08/26/24.

Certified Food Protection Manager: VACANT

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: AYNE ABEBE
AYNE ABEBE
LALD

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

Report #: 1029241254

m

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

08/26/24

No. of Repeat RF/PHI Categories Out

0

Time In

11:02:40

Legal Authority MN Rules Chapter 4626

Time Out

Best Home Health Care Service

Address

6044 Clinton Avenue South

City/State

Minneapolis, MN

Zip Code

55419

Telephone

6129909616

License/Permit #

0038373

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 Hygienic 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 procedure 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 procedures 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 labeled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

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

X

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

X

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)

Ayne

Date:

08/26/24

Inspector (Signature)

Trevor McCliment