Electronically Delivered

August 4, 2022

Administrator
Olus Home, Inc.
1850 7th Street East
Saint Paul, MN 55119

RE: Project Number(s) SL35381015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 8, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35381	A. BUILDING: _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLUS HOME INC	1850 7TH STREET EAST SAINT PAUL, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** 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: SL35381015 On July 5 through July 8, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six (6) residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included document titled, Food and Beverage Establishment Inspection Report, dated July 5, 2022, for the specific Minnesota	0 480		

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0 480	Continued From page 2 Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure appropriate personal protective equipment was worn in the facility and while providing cares. This had the potential to affect all six (6) 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	0 510		

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0 510	Continued From page 3 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: On July 5, 2022, at 10:00 a.m., upon entering the facility, contracted cleaning staff were observed not wearing a face mask. -at 10:08 a.m., licensed practical nurse (LPN)-C was observed in the facility and not wearing a face mask. On July 5, 2022, at 11:04 a.m., registered nurse (RN)-A arrived at the facility, and was observed not wearing a face mask. On July 6, 2022, at 8:12 a.m., LPN-C was observed to assist R1 with medication administration. LPN-C was not wearing a face mask or eye protection while administering medications to R1. -at 8:24 a.m., LPN-C was observed to assist R1 with blood glucose testing. LPN-C was not wearing a face mask or eye protection while checking R1's blood glucose level. On July 6, 2022, at 10:24 a.m., unlicensed personnel (ULP)-D stated he wore a mask at all times while in the facility, but did not wear eye protection aside from prescription eyeglasses. On July 6, 2022, at 9:00 a.m., licensed assisted living director (LALD)-B stated her understanding was she could not force staff to wear masks because it wasn't mandated. LALD-B further stated there was a supply of eye protection in the facility for staff to use during cares, going forward.	0 510		

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0 510	Continued From page 4 The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well fitting facemask. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The CDC COVID Data Tracker on July 5 and July 6, 2022, indicated Ramsey County, MN (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 5 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for four of four employees (registered nurse (RN)-A, licensed assisted living director (LALD)-B, licensed practical nurse (LPN)-C, and unlicensed personnel (ULP)-D), and TB training for two of four employees (RN-A, LPN-C), with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 6 The findings include: The Facility TB Risk Assessment dated May 1, 2022, identified the facility was at a low risk for transmission. RN-A was hired June 1, 2022, and provided assessment services for the residents of the facility. RN-A's employee record lacked documentation of TB training, baseline tuberculin skin test (TST) and symptom and history screening. LALD-B was hired March 1, 2010, and provided supervisory services at the facility. LALD-B's employee record lacked documentation of baseline tuberculin skin test (TST) and symptom and history screening. LPN-C was hired November 29, 2021, and provided direct care and supervisory services at the facility. LPN-C's employee record lacked documentation of TB training, baseline tuberculin skin test (TST) and symptom and history screening. ULP-D was hired February 2, 2021, and provided direct cares for residents of the facility. ULP-D's employee record lacked documentation of a baseline tuberculin skin test (TST) and symptom and history screening. On July 6, 2022, at 10:24 a.m. ULP-D stated he provided verification of a single TST completed "a few weeks" prior to hire, but did not recall filling out a symptom and history screening form. On July 6, 2021, at 1:55 p.m. LALD-B stated they did not recall completing a TB baseline screening, but could have been completed back in 2010	0 660		

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0 660	Continued From page 7 upon hire. LALD-B acknowledged the screening process likely was not completed for any of the staff due to RN position turnover. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's undated Tuberculosis Screening policy indicated, "For all employees or contract personnel providing direct client care, there shall be evidence of baseline TB screening consisting of two components: a. Assessing for current symptoms of active TB disease, (see attached screening tool) and b. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test." The policy further indicated, "All staff will receive education and training about TB. Training will be conducted prior to initial assignment and annually thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 8	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all six (6) residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 9 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-provided EP plan, undated, was reviewed and noted to lack individualized emergency procedures to include the following: -a risk assessment considering all hazards that may impact all or a portion of the facility; - a process for emergency preparedness cooperation with state and local EP officials/organizations; - a tracking system used to document locations of residents and staff; - the medical record documentation system to preserve resident information; - handling and use of volunteers; - how the facility would operate under an 1135 waiver; - a communication plan that included: - names and contact information for resident physicians, other facilities. On July 5, 2022, during a 1:55 p.m. interview, licensed assisted living director (LALD)-B acknowledged the EP plan was lacking some content. LALD-B indicated the plan would be updated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 730	Continued From page 10	0 730		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 11 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted March 13, 2020, and began receiving services under the assisted living licensure August 1, 2021. R1's service plan, dated June 14, 2022, indicated R2 received services for assistance with housekeeping (daily), laundry (2x weekly), shopping (1x weekly), making appointments (monthly, and as needed), 1:1 socialization (3x weekly, and as needed), medication reminders (daily), comprehensive assessment and skin	0 730		

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0 730	Continued From page 12 audit (weekly), vital signs and skin checks (daily), orientation and behavior management (daily). On July 5, 2022, at 3:25 p.m., licensed practical nurse (LPN)-C stated staff documented the services provided in the program notes for each resident. R1's program notes for June 1 through July 5, 2022, were reviewed. The program notes included entries dated June 11(vital signs, bath, nail care and nursing notes), June 13 (nursing notes), June 27 (nursing notes), and July 1, 2022 (meal and nursing notes). The record did not include consistent documentation of services provided. On July 6, 2022, during a 1:55 p.m. interview, licensed assisted living director (LALD)-B stated going forward, staff will be able to document cares in the electronic charting system. LALD-B indicated they were not aware staff was required to document all services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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	0 780		

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0 780	Continued From page 13 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; This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to provide smoke alarms on the upper level that are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 6, 2022, between 9:00 a.m. and 10:30 a.m., survey staff toured the facility with licensed	0 780		

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0 780	Continued From page 14 assisted living director (LALD)-B. During the facility tour, survey staff observed the following: 1. Smoke detectors on upper level were not interconnected with each other. 2. The fire alarm system had last been tested in 2019 per tag on alarm panel. LALD-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 15 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On July 6, 2022, from approximately 9:00 a.m. to 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the licensee lacked fire drills completed for the home in the last year. LALD-B provided posted floor plans, however, the postings lacked procedures directing resident movement, evacuation or	0 810		

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0 810	Continued From page 16 relocation during a fire. During interview on July 6, 2022 at 9:30 a.m., LALD-B verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01370 SS=D	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;	01370		

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01370	Continued From page 17 (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; (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 interview and record review, the licensee failed to ensure training and competency to include all required content was completed for one of one employee (unlicensed personnel (ULP)-D) with employee training record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-D was hired February 2, 2021, and provided direct cares for residents of the facility. ULP-D's employee record lacked documentation of training for the following topics:	01370		

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01370	Continued From page 18 -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -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; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning.	01370		

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01370	Continued From page 19 On July 6, 2022, at 1:55 p.m., licensed assisted living director (LALD)-B acknowledged training was incomplete for ULP-D. LALD-B indicated she would ensure all unlicensed staff complete required training topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 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	01440		

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01440	Continued From page 20 by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one unlicensed staff (unlicensed personnel (ULP)-D) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP-D was hired February 2, 2021, and provided direct cares for residents of the facility. ULP-D's employee record included a medication administration training, blood glucose testing training, and competency evaluations dated May 18, 2022. R1's medication administration record indicated ULP-D assisted R1 with medication administration on the following dates: June 1, 3, 8, 10, 14, 15, 17, and 29, and July 1-2, 2022. ULP-D's employee record lacked a 30-day supervision of performance of delegated tasks. On July 6, 2022, at 1:55 p.m., licensed assisted living director (LALD)-B indicated ULP-D's 30-day supervision was possibly done, but was unable to provide documentation.	01440		

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01440	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed orientation to assisted living facility licensing requirements and regulations before providing services for four of four employees (registered nurse (RN)-A, licensed assisted living director (LALD)-B, licensed practical nurse (LPN)-C, and unlicensed personnel (ULP)-D) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01460		

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01460	Continued From page 22 The findings include: The licensee converted to an Assisted Living license on August 1, 2021 RN-A RN-A was hired June 1, 2022, and provided assessment services for the residents of the facility. RN-A's employee record lacked documentation RN-A completed required orientation to assisted living licensing requirements and regulations with the required content. LALD-B LALD-B was hired March 1, 2010, and provided supervisory services at the facility. LALD-B's employee record lacked documentation LALD-B completed required orientation to assisted living licensing requirements and regulations with the required content. LPN-C LPN-C was hired November 29, 2021, and provided direct care and supervisory services at the facility. LPN-C's employee record lacked documentation that the following orientation topics were completed: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Home care/Assisted Living bill of rights - Handling of resident/clients' complaints, reporting of complaints, where to report - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01460		

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01460	Continued From page 23 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery and how they apply to direct support services provided by the staff person. ULP-D ULP-D was hired February 2, 2021, and provided direct cares for residents of the facility. ULP-D's employee record lacked documentation that the following orientation topics were completed: - Overview of Assisted Living statutes; - Handling of emergencies and use of emergency services; - Handling of residents' 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 Ombudsman for Long-Term Care, Office of 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; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 6, 2022, at 1:55 p.m., licensed assisted living director (LALD)-B acknowledged orientation	01460		

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01460	Continued From page 24 was lacking for all staff. LALD-B indicated she did not realize supervisory staff would need the same orientation provided to other staff, and would have all staff complete required orientation topics. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
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	01530		

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01530	Continued From page 25 each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for three of three employees (licensed assisted living director (LALD)-B, licensed practical nurse (LPN)-C, and unlicensed personnel (ULP)-D) with employee records reviewed. This had the potential to affect all six (6) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-B LALD-B was hired March 1, 2010, and provided supervisory services at the facility. LALD-B's employee record indicated a dementia care course was completed May 26, 2020, but lacked documentation LALD-B completed the required amount of dementia care training in the required topics. LPN-C LPN-C was hired November 29, 2021, and provided direct care and supervisory services at the facility.	01530		

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	35381	A. BUILDING: _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLUS HOME INC	1850 7TH STREET EAST SAINT PAUL, MN 55119

(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
01530	Continued From page 26 LPN-C's employee record lacked documentation LPN-C completed the required amount of dementia care training in the required topics. On July 5, 2022, at 3:05 p.m., LPN-C stated she completed some training modules online, but had not had any dementia care training. ULP-D ULP-D was hired February 2, 2021, and provided direct cares for residents of the facility. ULP-D's employee record lacked documentation ULP-D completed the required amount of dementia care training in the required topics. On July 6, 2022, at 10:24 a.m., ULP-D indicated he had some training provided upon hire, including dementia care training and VA training. On July 6, 2022, at 1:55 p.m., LALD-B stated she did not have any knowledge of dementia care training provided to staff. LALD-B further stated she was not aware it was a requirement. The licensee's Dementia Training policy, dated January 1, 2022, indicated, supervisors of direct care staff would complete eight (8) hours of initial training within 120 hours of the employment start date, and direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. The policy further indicated dementia care training would include: an explanation of Alzheimer's disease and other dementias, assistance with activities of daily living, problem solving with challenging behaviors, communication skills, and person centered planning and service delivery. No further information was provided.	01530		

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01530	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	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 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of	01620		

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01620	Continued From page 28 one resident (R1) receiving services with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 March 13, 2020, and began receiving services under the Assisted Living licensure August 1, 2021. R1's service plan, signed November 10, 2021, indicated R1 received services including assistance with housekeeping, transportation, meals, activities of daily living, bathing, and medication management. R1's record included a nursing assessment completed June 10, 2020, and a reassessment completed June 14, 2022, greater than 90 days after the previous assessment. R1's record included a Minnesota Department of Health and Human Services (DHS) assessment, completed June 3, 2022, but lacked nursing reassessments completed by the licensee at least every 90 days. On July 5, 2022, at 1:42 p.m., licensed assisted living director (LALD)-B verified the assessment completed June 3, 2022, was a DHS form completed by R1's case worker.	01620		

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01620	Continued From page 29 On July 6, 2022, at 8:52 a.m., LALD-B stated there were no current RN assessments for R1. LALD-B indicated there was repeated turnover in the RN position and they were unaware tasks that were to be done by the RN were not completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01820 SS=D	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 observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01820		

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01820	Continued From page 30 R1 was admitted March 13, 2020, and began receiving services under the Assisted Living licensure August 1, 2021. R1's service plan, signed November 10, 2021, indicated R1 received services including assistance with housekeeping, transportation, meals, activities of daily living, bathing, and medication management. On July 6, 2022, at 8:13 a.m., licensed practical nurse (LPN)-C was observed to administer medications to R1. R1's record included a list of prescriptions signed by a physician March 3, 2020. R1's record lacked current signed prescriptions. On July 5, 2022, at 2:14 p.m., licensed assisted living director (LALD)-B verified there was a current medication list for R1, but acknowledged it was not signed by a physician. LALD-B further stated the normal process was to have orders signed at the annual appointment, and R1 had an appointment coming up where the current orders would be signed. The licensee's Medication & Treatment Orders policy dated January 1, 2022, indicated the RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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01950	Continued From page 31	01950		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) specified, in writing, specific treatment instructions for each resident and documented those instructions in the resident record for one of one resident (R1) with record reviewed. 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 resident's health or safety, but was not likely to	01950		

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01950	Continued From page 32	01950		

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 March 13, 2020, and began receiving services under the Assisted Living licensure August 1, 2021.

On July 6, 2022, at 8:24 a.m. licensed practical nurse (LPN)-C was observed to assist R1 with blood glucose level monitoring.

R1's undated "Home Health Aid Care Plan" indicated R1 received assistance with blood glucose checks daily, but lacked specific treatment instructions related to blood glucose monitoring.

R1's treatment management plan dated June 14, 2022, indicated R1 received treatment services to include assistance with blood glucose monitoring delegated to unlicensed personnel (ULP). The treatment management plan lacked specific treatment instructions related to R1's treatment, and indicated specific instructions were located on the treatment administration record (TAR).

R1's medication administration record (MAR)/TAR for July, 2022, included documentation of blood glucose levels, but lacked specific treatment instructions related to R1's treatment.

On July 6, 2022, during a 1:55 p.m. interview, licensed assisted living director (LALD)-B acknowledged the specific treatment instructions

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01950	Continued From page 33 for R1 should be present in the resident record. LALD-B stated they were developing an updated service plan and treatment management plan for R1. The licensee's Medication & Treatment-Administration & Delegation policy dated January 1, 2022, indicated "When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee] will ensure that the registered nurse has: 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records 3. Communicated with the unlicensed personnel about the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
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	01970		

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01970	Continued From page 34 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 one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 March 13, 2020, and began receiving services under the Assisted Living licensure August 1, 2021. On July 6, 2022, at 8:24 a.m. licensed practical nurse (LPN)-C was observed to assist R1 with blood glucose level monitoring. R1's treatment management plan dated June 14, 2022, indicated R1 received treatment services to include assistance with blood glucose monitoring delegated to unlicensed personnel (ULP). R1's medication administration record (MAR)/TAR for July, 2022, indicated blood glucose levels were tested June 1-5, 2022.	01970		

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01970	Continued From page 35 R1's record lacked a signed prescriber order for blood glucose monitoring. On July 6, 2022, during a 1:55 p.m. interview, licensed assisted living director (LALD)-B acknowledged there was no current order for blood glucose monitoring for R1. LALD-B stated she had previously discussed, with LPN-C, the need to get an order for blood glucose testing, but they had not yet gotten the signed order. The licensee's Medication & Treatment Orders policy dated January 1, 2022, indicated the RN was responsible for assuring current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the	02240		

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02240	Continued From page 36 Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current "Minnesota Bill of Rights for Assisted Living Residents" was provided to the resident and a written acknowledgement received for one of one resident (R1) with record reviewed.	02240		

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02240	Continued From page 37 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: The facility converted to an Assisted Living license on August 1, 2021. R1 was admitted March 13, 2020, and began receiving services under the Assisted Living licensure August 1, 2021. R1's assisted living contract included an undated "Health Care Bill of Rights for Residents of Supervised Living Facilities", signed by the resident representative November 10, 2021. R1's record lacked documentation of receipt of the current Assisted Living Bill of Rights. On July 6, 2022, at 8:52 a.m., licensed assisted living director (LALD)-B stated residents had not signed the current Assisted Living Bill of Rights. LALD-B further stated she did not believe they had received it. LALD-B indicated she was unaware of the Bill of Rights requirements for Assisted living and was depending on the registered nurse (RN) to update documents. The licensee's Bill of Rights policy, dated January 1, 2022, indicated, "[Licensee] will provide each resident with the Assisted Living Care Bill of Rights."	02240		

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02240	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	03090		

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03090	Continued From page 39 On January 5, 2022, at approximately 10:00 a.m. upon entrance to the facility, the surveyor observed the facility's front door and common areas and noted the lack of the required posting of the electronic monitoring notice to visitors. On January 5, 2022, at 10:20 a.m. during the entrance conference, licensed assisted living director (LALD)-B verified the licensee did not have an electronic monitoring notice to visitors sign posted near the entrance of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *07/05/22*
Time: 11:30:00
Report: 1031221075

Food and Beverage Establishment Inspection Report

Location:
Olus Home Inc
1850 7th Street East
St Paul, MN55119
Ramsey County, 62

Establishment Info:
ID #: 0038516
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513303363
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.

3-300B Protection from Contamination: cross-contamination, eggs
3-302.11A(1) ***** Priority 1 *****

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

RAW CHICKEN FOUND ABOVE GREENS MIX AND SHELL EGGS FOUND ABOVE LEAFY GREENS IN REFRIGERATOR. ***INSTRUCTED EMPLOYEE TO PROPERLY SEPARATE ITEMS*** KEEP ALL RAW PROTEINS STORED BELOW READY-TO-EAT FOODS.

Comply By: 07/07/22

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****

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

OPEN CONTAINER OF PREGO FOUND IN CUPBOARD MEASURED 63F. ***PREGO DISCARDED*** READ LABELS TO DETERMINE IF FOODS SHOULD BE REFRIGERATED AFTER OPENING.

Comply By: 07/07/22

3-700 Contaminated Food: discarded
3-701.11A ***** Priority 1 *****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

ROTTEN ONION FOUND IN CUPBOARD. ***ITEM DISCARDED*** KEEP FOOD STORED TOGETHER IN SPECIFIC AREAS SO FOOD ITEMS ARE NOT MISPLACED.

Comply By: 07/07/22

7-200 Toxic Supplies and Applications

7-201.11A ***** Priority 1 *****

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

BLEACH IN CUPBOARD FOUND DIRECTLY ABOVE CANNED SOUP. ***INSTRUCTED EMPLOYEE TO REMOVE SOUP FROM AREA*** DO NOT STORE CHEMICALS AND FOOD PRODUCTS IN CLOSE PROXIMITY.

Comply By: 07/07/22

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.

ESTABLISHMENT DOES NOT HAVE SANITIER TESTING KIT ON SITE. PROVIDE AND USE TEST KIT TO CHECK SANITIZER CONCENTRATION.

Comply By: 07/11/22

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

3-302.11A(4)

MN Rule 4626.0235A(4) Protect food from cross-contamination by packages or covered containers.

OIL AND SYRUP IN CUPBOARD MISSING LIDS. ***OIL DISCARDED DUE TO SEDIMENT FOUND IN OIL.*** ENSURE ALL LIDS/TOPS REMAIN WITH FOOD ITEM AFTER OPENING.

Comply By: 07/07/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

SNACKS STORED IN BASEMENT ON FLOOR. ENSURE ALL FOODS ARE STORED AS INSTRUCTED ABOVE.

Comply By: 07/07/22

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

CHICKEN IN BOWL OF WATER FOUND IN MICROWAVE. EMPLOYEE STATED IT WAS TEMPORARILY STORED THERE AND WAS THAWING ON THE COUNTER. ***DISCONTINUE PRACTICE*** ONLY THAW FOODS USING THE METHODS LISTED ABOVE.

Comply By: 07/07/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASH REMINDER SIGNS MISSING FROM BATHROOM AND HANDWASH STATION.

Comply By: 07/11/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

HANDLE ON CUPBOARD NOT PROPERLY ATTACHED. SHELF UNDER SINK BROKEN. REPAIR OR REPLACE HANDLE AND SHELF.

Comply By: 07/14/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

MULTIPLE SHELVES FOUND WITH FOOD/DIRT/DEBRIS ON SHELF AND LITTLE/NO ORGANIZATION. CLEAN SHELVES, SEPERATE FOOD FROM MISC ITEMS AND ORGANIZE SHELVING. SET SCHEDULE TO ENSURE SHELVES CLEANED REGULARLY AND KEPT ORGANIZED.

Comply By: 07/12/22

Food and Equipment Temperatures

Process/Item: Cold Hold/Leafy Greens
Temperature: 37 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Hot Dogs
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Prego; OPEN
Temperature: 63 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	1	6

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. ***No saving and reheating of foods of preparation of foods the day prior.*** Any remaining food from meals to be

removed/discarded at end of day.

- Residents have their own food/beverages in separate refrigerator that they prepare themselves.

- Staff should be washing hands every time they prepare foods in kitchen.

- Gloves should be used for single-purpose only; switch gloved whenever leaving kitchen to do other work.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Extra care needs to be taken when cleaning behind cabinet hardware so debris does not build up.

- Establishment does not have 3-comp sink or commercial dishwasher - can use dishwasher to wash and rinse, but will need to use bus tub or sink basin to sanitize dishes, as discussed during inspection.

- 2-Comp sink should have one basin designated for handwashing and the other for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

- Organization is lacking from the kitchen and CAUSING MAJORITY OF VIOLATIONS. Keep tools and office supplies separate from food and cookware.

- When preparing food from raw, make sure to use a thermometer to check temperatures.

AFTER DISCUSSION WITH LATASHA ABOUT FOOD SAFETY, KITCHEN ORGANIZATION, AND GENERAL DUTIES, IT IS RECOMMENDED THAT SHE TAKE A SERVSAFE OR SIMILAR COURSE.

ESTABLISHMENT DOES NOT HAVE A CFPM.

ALL VIOLATIONS DISCUSSED WITH LATASHA AFTER INSPECTION.

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

I acknowledge receipt of the Environmental Health inspection report number 1031221075 of 07/05/22.

Certified Food Protection Manager: Alicia E. Carey

Certification Number: FM108517 Expires: 11/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Latasha Taylor
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760

chris.j.foster@state.mn.us

Report #: 1031221075

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	4	Date	07/05/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

Establishment	Address	City/State	Zip Code	Telephone
Olus Home Inc	1850 7th Street East	St Paul, MN	55119	6513303363

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038516		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	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) **Date:** 07/08/22

Inspector (Signature)