Electronically Delivered

May 2, 2023

Licensee
Abrahams Bosom Care
305 Winthrop Street
Saint Paul, MN 55119

RE: Project Number(s) SL38522015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on April 19, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

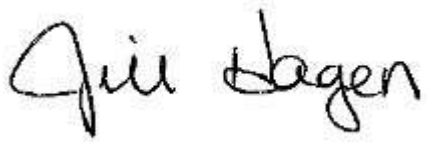
Please address your cover letter for reconsideration requests to:

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

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.

If you have any questions, please contact me.

Sincerely,



Jill Hagen, Supervisor
State Rapid Response Team
Email: jill.hagen@state.mn.us
Telephone: 218-770-8646 Fax: 651-215-6894

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38522 | A. BUILDING: _____ B. WING _____ | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ABRAHAMS BOSOM CARE | 305 WINTHROP STREET SAINT PAUL, MN 55119 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>#SL38522015-0<br><br>On April 17 and 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and<br>the following correction orders are issued. At the time of the survey and investigation, there were three residents receiving services under the provider's Provisional Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>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).<br>Findings include:<br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 19, 2023, for the specific Minnesota Food Code deficiencies.<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 630 SS=D | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(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 | 0 630 | | |

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| 0 630 | Continued From page 2<br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the licensee failed to ensure the individualized abuse prevention plan (IAPP) was developed to include the required content for two of four (R1, R2) residents with records reviewed. As a result, residents lacked appropriate plan of action for listed vulnerabilities.<br><br>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).<br><br>Findings include:<br><br>R1 admitted to the facility on June 30, 2022, with diagnoses that included schizophrenia, chronic low back pain, epilepsy, polysubstance abuse, and antisocial behavior. R1's plan of care dated April 17, 2023, indicated R1 received assistance with medication administration, safety checks, dressing and grooming cues, and behavior monitoring for anxiety and paranoia.<br><br>R1's Individual Abuse Prevention Plan (IAPP) dated April 11, 2023, indicated R1's vulnerabilities to be housekeeping and laundry, medication management, and social/cognitive vulnerability due to paranoid schizophrenia. R1's IAPP lacked | 0 630 | | |

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| 0 630 | Continued From page 3<br>plan of action for all identified vulnerabilities.<br><br>R2 admitted to the facility on May 20, 2022, with diagnoses that included seizure disorder, depression, schizoaffective disorder, and severe alcohol use disorder.<br><br>R2's Individual Abuse Prevention Plan (IAPP) dated indicated R2's vulnerabilities to be alcohol use, social/cognitive vulnerabilities due to anxiety, depression, paranoia, and schizoaffective disorder. R2's individual IAPP lacked plan of action for all identified vulnerabilities.<br><br>During Review of R1 and R2's record with the licensed assisted living director (LALD)-A on April 17, 2023, at 2:00 p.m., LALD-A acknowledged R1 and R2's IAPP's lacked plan of action for vulnerabilities.<br><br>The licensee's policy and procedure titled Vulnerable Adult and Maltreatment-Communication, Prevention, and Reporting dated June 1, 2022, indicated the licensee develops individual vulnerable abuse prevention plans to identify vulnerability risks and develops measures to minimize maltreatment based on identified information.<br><br>Time period for correction: Seven (7) days | 0 630 | | |
| 0 650 SS=F | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, | 0 650 | | |

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| 0 650 | Continued From page 4<br><br>registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employee records included all required content to include annual evaluations for four of six unlicensed personnel (ULP), and one registered nurse (RN) (ULP-B, ULP-C, ULP-F, ULP-H, RN-G) with employee records reviewed.<br><br>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).<br><br>Findings include: | 0 650 | | |

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| 0 650 | Continued From page 5<br><br>ULP-B was hired on October 14, 2021. ULP-B's employee record lacked evidence of an annual evaluation for 2022.<br><br>ULP-C was hired on October 27, 2020. ULP-C's employee record lacked evidence of an annual evaluation for 2021 and 2022.<br><br>ULP-F was hired on October 26, 2020. ULP-F's employee record lacked evidence of an annual evaluation for 2021 and 2022.<br><br>ULP-H was hired on October 27, 2020. ULP-H's employee record lacked evidence of an annual evaluation for 2022.<br><br>RN-G was hired on September 22, 2021. RN-G's employee record lacked evidence of an annual evaluation for 2022.<br><br>On April 17, 2023, at 2:30 p.m., licensed assisted living director (LALD)-A acknowledged annual evaluations were not up to date.<br><br>The licensee's policy titled Employee Evaluation undated, indicated 1. All staff would be given an employee evaluation at least annually. 7. The evaluation form is to be signed by the supervisor and the employee. The original signed form is placed in the employee file and a copy of the completed and signed form will be given to the employee.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 650 | | |

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| 0 680 | Continued From page 6 | 0 680 | | |
| 0 680 SS=D | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all the required components included in Appendix Z. This had the potential to affect all residents, staff, and visitors during an emergency.<br><br>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 7<br>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).<br><br>Findings include:<br><br>During the Provisional Assisted Living Facilities (PALF) survey on April 17, 2023, at 2:30 p.m., the Licensed Assisted Living Director (LALD)-A provided a three-ring binder that contained policies that included emergency policies and procedures. LALD-A acknowledged the EPP was incomplete and was missing the information listed below. LALD-A stated he was working with a consultant to complete all documents.<br><br>The licensee's Disaster Plan lacked the following required content:<br>-Names and contact information<br>-Alternate means of communication<br>-Methods for sharing information<br>-Sharing information on occupancy/needs<br>-Family notifications<br><br>Licensee policy titled Emergency Preparedness Plan dated June 1, 2022, indicated it is the intent of the licensee to have in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |

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| 0 780 | Continued From page 8 | 0 780 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed provide smoke alarms outside and in the immediate vicinity of the sleeping rooms throughout the facility. This deficient condition had the ability to affect all staff and residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 780 | | |

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| 0 780 | Continued From page 9<br>safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>Findings include:<br><br>On a facility tour on April 19, 2023, at approximately 12:30 p.m. with licensed assisted living director (LALD)-A, it was observed that the facilities smoke alarms were not interconnected so that activation of one alarm activates all alarms throughout facility.<br><br>This deficient finding was visually verified by LALD-A at the time of discovery.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair | 0 800 | | |

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| 0 800 | Continued From page 10<br>and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>Findings include:<br><br>On a facility tour on April 19, 2023, at approximately 12:30 p.m. with licensed assisted living director (LALD)-A it was observed that the latch on the storm door leading from the marked exit door out of the dining room would not operate from the interior in order to open the door.<br><br>It was observed that an exit sign was located at the door leading to the attached garage in the basement. Exits are required to be maintained and lead directly to the exterior and not through a higher hazard room.<br><br>These deficient conditions were visually verified by LALD-A accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The | 0 810 | | |

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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 |
|---|---|---|---|---|
| 0 810 | Continued From page 11<br>plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38522 | A. BUILDING: _____ B. WING _____ | 04/19/2023 |

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|---|---|---|---|---|
| 0 810 | Continued From page 12<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>Findings include:<br><br>A record review of available documentation and interview were conducted on April 19, 2023, at approximately 11:45 a.m. of documents provided by licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.<br><br>Record review of the available documentation indicated the fire safety and evacuation floor plan did not include numbers for resident rooms.<br><br>Record review of the available documentation indicated that the licensee did not have detailed fire protection procedures necessary for residents located within the plan.<br><br>Record review of the available documentation indicated the fire safety and evacuation plan did not include procedures for employees in regard to resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br><br>Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. | 0 810 | | |

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| 0 810 | Continued From page 13<br>Training records were maintained in the computer and not available for review or specific to fire safety and evacuation.<br><br>Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation.<br><br>Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required.<br><br>All deficiencies were verified by LALD-A during the interview at approximately 11:45 a.m.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 01460 SS=D | 144G.63 Subdivision 1 Orientation of staff and supervisors<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure staff completed | 01460 | | |

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|---|---|---|---|---|
| 01460 | Continued From page 14<br>orientation to assisted living facility licensing requirements and regulations before providing direct care services for one of one registered nurse (RN-G) with records reviewed.<br><br>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).<br><br>Findings include:<br><br>RN-G was hired on December 12, 2022. RN-G's employee record lacked evidence of completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents.<br><br>During review of RN-G's employee record with the licensed assisted living director (LALD)-A on April 17, 2023, at 2:00 p.m., LALD-A acknowledged RN-G's employee record lacked orientation to the assisted living facility licensing requirements and regulations.<br><br>The licensee policy titled Orientation of Staff and Supervisors & Content dated June 1, 2022, indicated all employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The materials and/or type of training (i.e. video, lecture, reading, etc.) will be documented for compliance.<br><br>No further information was provided. | 01460 | | |

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| 01460 | Continued From page 15<br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01460 | | |
| 01480 SS=F | 144G.63 Subd. 3 Orientation to resident<br><br>Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident, and the services to be provided, for five of six unlicensed personnel (ULP) and one registered nurse (RN) (ULP-B, ULP-C, ULP-D, ULP-E, ULP-F, and RN-G) with employee records reviewed. This had the potential to affect the health and safety of all residents.<br><br>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).<br><br>Findings include:<br><br>ULP-B was hired on October 14, 2021. ULP-B's employee record lacked evidence that resident orientation was completed prior to providing services. The record contained a form for | 01480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01480 | Continued From page 16<br>resident orientation however, the form was blank.<br><br>ULP-C was hired on October 27, 2020. ULP-C's employee record lacked evidence that resident orientation was completed prior to providing services. The record contained a form for resident orientation however, the form was blank.<br><br>ULP-D was hired on July 8, 2022. ULP-D's employee record lacked evidence that resident orientation was completed prior to providing services. The record contained a form for resident orientation however, the form was blank.<br><br>ULP-E was hired on June 15, 2022. ULP-E's employee record lacked evidence that resident orientation was completed prior to providing services. The record contained a form for resident orientation however, the form was blank.<br><br>ULP-F was hired on October 26, 2020. ULP-F's employee record lacked evidence that resident orientation was completed prior to providing services. The record contained a form for resident orientation however, the form was blank.<br><br>RN-G was hired on September 22, 2021. RN-G's employee record lacked evidence that resident orientation was completed prior to providing services. The record contained a form for resident orientation however, the form was blank.<br><br>During review of employee records with the licensed assisted living director (LALD)-A on April 17, 2023, at 2:00 p.m., LALD-A acknowledged that employee records for ULP-B, ULP-C, ULP-D, ULP-E, ULP-F, and RN-G lacked completed resident orientation documentation.<br><br>The licensee's policy titled Orientation and | 01480 | | |

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| 01480 | Continued From page 17<br><br>Training undated indicated 5. Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01480 | | |

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

Type: Full
Date: *04/19/23*
Time: 15:17:41
Report: 8058231079

# Food and Beverage Establishment Inspection Report



**Location:**
Abrahams Bosom Care
305 Winthrop Street
St Paul, MN55119
Ramsey County, 62

**Establishment Info:**
ID #: 0041188
Risk:
Announced Inspection: No

**License Categories:**

Expires on: 12/31/23

**Operator:**

Phone #:
ID #:

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

The following orders were issued during this inspection.

**2-100 Supervision**

2-102.12AMN

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

TWO INDIVIDUALS HAVE FOOD SAFETY TRAINING BUT HAVE NOT TRANSFERRED THE CERTIFICATE TO A CFPM - APPLICATION PROVIDED

*Comply By: 06/30/23*

**Food and Equipment Temperatures**

Process/Item: HOT DOG
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

RESIDENTIAL KITCHEN, 5 TOTAL OCCUPANT LIMIT - 3 CURRENT RESIDENTS
FINISHES ARE RESIDENTIAL - WOOD CABINETS, PAINTED SHEETROCK

ABRAHAM WOLFE - ESTABLISHMENT REP

Type: Full
Date: *04/19/23*
Time: 15:17:41
Report: 8058231079
Abrahams Bosom Care

# Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058231079 of 04/19/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Establishment Representative

Signed:_____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us