



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

May 22, 2025

Licensee  
The James Inc  
10040 Nord Road  
Bloomington, MN 55437

RE: Project Number(s) SL33681016

Dear Licensee:

On April 16, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 23, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Renee L. Anderson'.

Renee L. Anderson, Supervisor  
State Evaluation Team  
Email: Renee.L.Anderson@state.mn.us  
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

February 28, 2025

Licensee  
The James Inc.  
10040 Nord Road  
Bloomington, MN 55437

RE: Project Number(s) SL33681016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

### **STATE CORRECTION ORDERS**

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

### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

**0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$3,000.00**  
**1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

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

#### **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in

*The James Inc.*  
*February 28, 2025*  
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a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto:susan.winkelmann@state.mn.us) or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Renee L. Anderson".

Renee Anderson, Supervisor  
State Evaluation Team  
Email: [renee.anderson@state.mn.us](mailto:renee.anderson@state.mn.us)  
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>33681</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/23/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE JAMES INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10040 NORD ROAD BLOOMINGTON, MN 55437</b>
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0 000	<p><b>Initial Comments</b></p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p>SL33681016-0</p> <p>On January 21, 2025, through January 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.</p> <p>An immediate correction order was identified on January 21, 2025, issued for SL33681016-0, tag identification 1290.</p> <p>During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.</p> <p>An immediate correction order was identified on January 22, 2025, issued for SL33681016-0, tag identification 0780.</p> <p>During the course of the survey, the licensee took</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>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.</b></p>	
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Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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0 000	Continued From page 1  action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000		
0 460 SS=F	<p><b>144G.41 Subdivision 1 Minimum requirements</b></p> <p>(5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week;            (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;            (7) permit residents access to food at any time;            (8) allow residents to choose the resident's visitors and times of visits;            (9) allow the resident the right to choose a roommate if sharing a unit;            (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;</p> <p>This MN Requirement is not met as evidenced by:            Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week for two of two residents (R1, R2).</p> <p>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</p>	0 460		

Minnesota Department of Health

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0 460	<p>Continued From page 2</p> <p>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).</p> <p>The findings include:</p> <p>On January 21, 2025, at 12:20 p.m., during a tour of the facility, the surveyor observed R1 and another resident's bedrooms were located on the main level of the facility, and R2's bedroom was located on the lower level of the facility.</p> <p>R1 R1 had diagnoses including schizophrenia , anxiety, suicidal, major depression, and Aspergers.</p> <p>R1's service plan dated June 5, 2024, indicated R1 received services including assistance with medication management, meals, and management of behaviors including "cognitive/mental health need," wandering and elopement, property destruction, physical aggression, verbal aggression, and self-injurious behavior.</p> <p>R2 R2's service plan dated December 20, 2024 indicated R2 received services including assistance with medication management, laundry, housekeeping, meals, and management of behaviors including property destruction, physical aggression, verbal aggression, and self-injurious behavior.</p> <p>On January 21, 2025, at 11:58 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated there was no call system at the facility for residents to summon assistance.</p>	0 460		
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0 460	Continued From page 3  LALD-A further stated residents did not have cell phones to call staff.  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services  (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a	0 480		

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0 480	<p>Continued From page 4</p> <p>manner that prevents contamination before storage;</p> <p>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;</p> <p>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;</p> <p>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and</p> <p>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>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.</p> <p>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).</p>	0 480		

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0 480	Continued From page 5  The findings include:  Please refer to the document titled, Food and Beverage Establishment Inspection Reports (FBEIR) dated, January 22, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.  TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records  (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	0 650		

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0 650	<p>Continued From page 6</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees, (registered nurse (RN)-B).</p> <p>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).</p> <p>The findings include:</p> <p>RN-B was hired February 22, 2010, to provide direct cares for the licensee's residents.</p> <p>On January 22, 2025, at 8:45 a.m., RN-B was observed assisting residents with medication administration.</p> <p>RN-B's employee record included a performance review form dated March 14, 2024. The form was not completed, and not signed by the licensee or RN-B. RN-B's record lacked documentation of an annual performance review to identify areas of improvement needed, and training needs.</p> <p>On January 23, 2025, at 1:00 p.m., during the exit conference, licensed assisted living director (LALD)-A stated they were in the process of getting records in order, and was not sure why the performance review was not in RN-B's employee record.</p> <p>The licensee's undated employee evaluation</p>	0 650		
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0 650	Continued From page 7  policy indicated an employee evaluation would be completed at least annually. The policy further indicated the original signed form would be placed in the employee's personnel file and a copy of the completed and signed form would be given to the employee.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness  (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680		

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0 680	<p>Continued From page 8</p> <p>requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all three residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's hazard vulnerability assessment (HVA), undated, lacked evidence it had been reviewed annually.</p> <p>The licensee's EP plan, last reviewed April 20, 2024, lacked the following required content: -emergency prep training program which includes maintain documentation of all EP training and EP training annually; and -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise).</p> <p>On January 22, 2025, licensed assisted living director (LALD)-A stated the hazard vulnerability</p>	0 680		

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0 680	Continued From page 9  assessment had not been updated, and the EP plan had not been developed in accordance with the HVA.  The licensee's emergency and disaster preparedness policy revised April 20, 2022, indicated the licensee would have an EP policy and procedure in place that was effective and compliant with the centers for medicare and medicaid services (CMS) state operations manual appendix Z.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment  for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing	0 780		

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0 780	<p>Continued From page 10</p> <p>buildings may be battery operated;</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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).</p> <p>The findings include:</p> <p>On January 22, 2024, from 10:45 a.m. to 11:30 a.m., the surveyor toured the facility with registered nurse (RN)-B. Survey staff asked RN-B to initiate a test of the smoke alarms throughout the facility.</p> <p>Upon testing, it was found that the smoke alarms in resident rooms 1, 4, 5, and 6 were not sounding when tested. RN-B stated that all the smoke alarms batteries need to be replaced.</p> <p>The smoke alarm in resident rooms 2 was missing the cover and pieces of the smoke alarm</p>	0 780	<p>During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.</p>	

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0 780	<p>Continued From page 11</p> <p>were hanging down. No battery was installed in the smoke alarm. RN-B stated that there was no need to test is since it was not working.</p> <p>The smoke alarm in resident room 3 was missing. There was a bracket designed to hold the smoke alarm on the ceiling, but there was no smoke alarm. RN-B stated they did not know where the smoke alarm was.</p> <p>The smoke alarm in the basement located between resident rooms 5, and 6 would not operate when tested.</p> <p>Smoke alarms are required in each room used for sleeping purposes. Smoke alarms are required outside each separate sleeping area in the immediate vicinity of bedrooms. Smoke alarms are required on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p>	0 780		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:</p>	0 800		

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0 800	<p>Continued From page 12</p> <p>Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On January 22, 2025, from 10:45 a.m. to 1:30 p.m., the surveyor toured the facility with registered nurse (RN)-B. The following was observed.</p> <p><b>SMOKING AREAS:</b> In the rear of the facility under the deck there were cigarette butts that were scattered around on the ground mixed with dry dead leaves. The ashtray in this area was a used cardboard coffee can. The coffee can was tipped on its side and was being used to wedge the screen door open.</p> <p>Ash trays shall be noncombustible and placed on a sturdy surface. Cigarettes shall not be discarded in a manner that may cause an unwanted fire.</p> <p><b>GENERAL MAINTENANCE:</b></p>	0 800		

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0 800	<p>Continued From page 13</p> <p>The wallpaper behind the door in resident room 2 was peeling off the wall and hanging down.</p> <p>The wallpaper under the single window in resident room 5 was peeling off the wall and hanging down.</p> <p>The closet door in resident room 6 had holes in it.</p> <p>There was a drywall patch next to the closet door in resident room 6 that was not completed. It lacked sanding and paint.</p> <p>The rim board that supports the deck was rotted and missing in the northeast corner of the deck.</p> <p>The front door has 3 locks on it. It had a lockable doorknob, a deadbolt, and a chain lock. Exit doors are only allowed to have two locks.</p> <p>In the front entry to the facility there is missing flooring where a wall had been removed previously.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <p>(1) location and number of resident sleeping rooms;</p> <p>(2) staff actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p>	0 810		

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0 810	<p>Continued From page 14</p> <p>(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.</p> <p>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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</p>	0 810		

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0 810	<p>Continued From page 15</p> <p>the residents).</p> <p>The findings include:</p> <p>On January 22, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p><b>FIRE SAFETY AND EVACUATION PLAN:</b> The licensee's FSEP, titled "Fire Policy", dated January 2, 2023, failed to include the following:</p> <p>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.</p> <p>The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.</p> <p>The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs</p>	0 810		

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0 810	<p>Continued From page 16</p> <p>of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.</p> <p>On January 22, 2025, at 1:20 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility.</p> <p><b>TRAINING:</b> The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. LALD-A stated that training is not offered to residents because they don't want it.</p> <p>The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated that employees receive training on the FSEP at orientation. No training documentation was provided.</p> <p><b>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</b></p>	0 810		
01290 SS=I	<p><b>144G.60 Subdivision 1 Background studies required</b></p> <p>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be</p>	01290		

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01290	<p>Continued From page 17</p> <p>construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain a cleared department of human services (DHS) Net Study 2.0 background study prior to having access to residents, for two of two employees (registered nurse (RN)-B and unlicensed personnel (ULP)-C). This had the potential to affect all three residents and staff.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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).</p> <p>The findings include:</p> <p>RN-B RN-B was hired on September 1, 2006 by the licensee to provide direct care and services to the licensee's residents and supervise unlicensed personnel under the licensee's assisted living license.</p>	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	<p>Continued From page 18</p> <p>RN-B's employee record included two background study clearance forms dated September 24, 2006, and November 30, 2006. Neither study was associated with an active health facility identification number (HFID). The record lacked a current DHS background study affiliated with the licensee's HFID.</p> <p>ULP-C ULP-C was hired by the licensee on December 3, 2018, to provide direct care services to the licensee's residents.</p> <p>ULP-C's employee record included a background study clearance form dated December 3, 2018. The study was not associated with an active HFID. The record lacked a current DHS background study affiliated with the licensee's HFID.</p> <p>On January 27, 2025, at 2:20 p.m. RN-B stated, "I am an RN. I just assumed my background study was valid. I was not knowledgeable regarding the affiliation with the HFID number. I thought I could work anywhere."</p> <p>On January 27, 2025, at 2:44 p.m licensed assisted living director (LALD)-A confirmed RN-B and ULP-C provided direct care services to residents at the facility. LALD-A further explained a background study was not completed for RN-B or ULP-C. LALD-A stated a background clearance study was only done for the LALD because RN-B and ULP-C already had background clearance completed.</p> <p>The Background Studies policy, dated June 2021, indicated the licensee conducted a Minnesota Department of Human Services, background</p>	01290		

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01290	Continued From page 19  study on all employees,volunteers and contracters. The policy indicated that no employee may provide direct services or have independent contact with residents until acceptable results have been received, except under the direct supervision (eyesight) of another qualified staff person.  No further information was provided.  TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training  (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01500		

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01500	<p>Continued From page 20</p> <p>residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees, registered nurse (RN-B).</p> <p>This practice resulted in a level two violation (a</p>	01500		

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01500	<p>Continued From page 21</p> <p>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).</p> <p>The findings include:</p> <p>RN-B was hired February 22, 2010, and began providing direct care services under the Assisted Living Facility license August 1, 2021.</p> <p>RN-B's record included initial orientation completed September 3, 2021 through September 11, 2021. The record lacked evidence of at least eight hours of annual training for every 12 months of employment, including the following required topics:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>33681</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/23/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE JAMES INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10040 NORD ROAD BLOOMINGTON, MN 55437</b>
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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
01500	<p>Continued From page 22</p> <p>disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>RN INTERVIEW</p> <p>LALD INTERVIEW</p> <p>POLICY</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01500		

Type: Full  
Date: 01/22/25  
Time: 08:12:57  
Report: 1018251013

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

The James Inc  
10040 Nord Road  
Bloomington, MN55437  
Hennepin County, 27

**Establishment Info:**

ID #: 0037872  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 9528314591  
ID #:

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

The following orders were issued during this inspection.

### 2-200 Employee Health

#### 2-201.11C

**\*\* Priority 1 \*\***

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

ESTABLISHMENT WAS UNABLE TO PRODUCE AN ILLNESS LOG AT THE TIME OF INSPECTION. ILLNESS LOG SENT WITH REPORT.

*Comply By: 01/23/25*

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

#### 6-501.12A

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

FLOOR, WALLS AND CEILINGS WERE OBSERVED TO HAVE HEAVY DEBRIS BUILD UP. CABINETS AND COUNTER TOPS WERE ALSO OBSERVED TO HAVE DEBRIS BUILD UP. DISCUSSED WITH MANAGER TO HAVE THESE AREAS CLEANED.

*Comply By: 01/24/25*

### Surface and Equipment Sanitizers

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

### Food and Equipment Temperatures

Type: Full  
Date: 01/22/25  
Time: 08:12:57  
Report: 1018251013  
The James Inc

# Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ CREAM CHEESE  
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE  
Violation Issued: No

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

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ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

ESTABLISHMENT IS DOING ALL SAME DAY SERVICE OF FOODS.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN FAIR CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

KITCHEN HAS A TWO BASIN SINK AND ONE SINK SPECIFICALLY FOR HAND WASHING.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE. TEST STRIP INDICATED APPROPRIATE TEMPERATURE WAS ACHIEVED DURING CYCLE.

ESTABLISHMENT HAS A NEEDLE POINT THERMOMETER FOR CHECKING FOOD TEMPERATURES.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

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

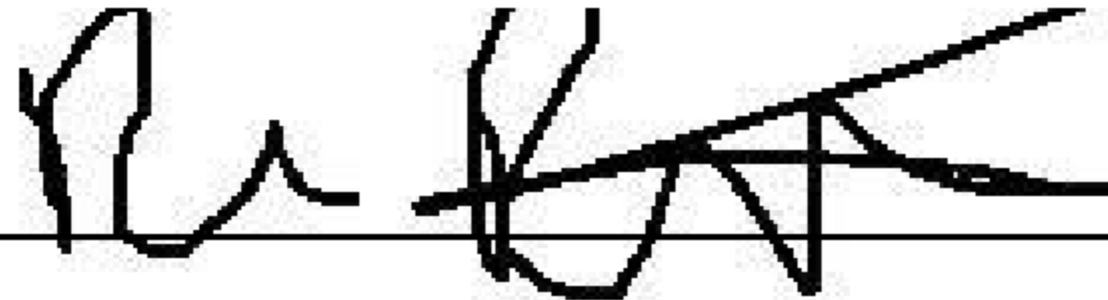
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018251013 of 01/22/25.

Certified Food Protection Manager: JAMES IMASUEN

Certification Number: FM112312 Expires: 08/02/25

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_  
JAMES IMASUEN  
MANAGER

Signed:  \_\_\_\_\_  
Rebecca Prestwood  
Sanitarian 3  
6512013777  
rebecca.prestwood@state.mn.us