Electronically Delivered

October 23, 2024

Licensee
Care Plus Home Care LLC
6019 Colfax Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL36155015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 17, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36155015 On September 16, 2024, through September 17, 2024, 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 license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staff posting included all the required elements, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 470	Continued From page 2 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings included: During the entrance conference on September 16, 2024, at 11:39 a.m. licensed assisted living director (LALD)-A indicated the following staffing hours: Day shift: 6:30 a.m. - 2:30 p.m. Evening shift: 2:30 p.m. - 10:30 p.m. Night shift: 10:30 p.m. - 6:30 a.m. LALD-A stated one direct care staff was scheduled for each shift. Also, an additional staff member would come in for two hours on the day and evening shifts to assist with two-person transfers for R1. During the facility tour on September 16, 2024, at 12:26 p.m., the surveyor observed a copy of the licensee's posted staff schedule on a bulletin board in the kitchen. The posting indicated staff schedule for the AM, PM, and overnight shift; the posting did not include the hours of each shift, nor did it include the additional staff scheduled for two hours on the day and evening shift. On September 16, 2024, at 1:00 p.m. LALD-A and manager (M)-B stated the staff posting did not include the hours of each shift or the additional two-hour shift on the day and evening shift. M-B stated he was the staff that would usually come in for the two-hour shifts but didn't add it to the posting as he was "not getting paid" to come. The licensee's Direct-care Staffing Plan reviewed July 8, 2024, indicated: The current staff-to-client	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 470	Continued From page 3 ratio is 1:3. There is an additional staff that comes in for two hours on day and evening shifts to help with cares and Hoyer Lift transfer. Also, there is an on-call direct-care staff that will be call to [licensee name] when the need arises. The licensee's 2.15 Staffing policy dated August 1, 2021, indicated: 5. A daily staffing schedule is prepared by the clinical nurse supervisor and addresses: Home health aide work schedules for each home health aide showing all work shifts with days/hours worked. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 620	Continued From page 4 admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 620	Continued From page 5 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1) who eloped from the 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, 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: During the entrance conference on September 16, 2024, at 11:39 a.m. licensed assisted living director (LALD)-A stated vulnerable adult reporting should occur immediately but not exceed 24 hours. Manager (M)-B stated having one new resident (R1) who had left the facility in his electric wheelchair in the evening and didn't return until the next morning. Staff attempted to contact him by phone, but he didn't answer. R1's parent was contacted, and a missing person report was filed with the police. M-B stated he did not report the incident to MAARC as R1 returned to the facility in less than 24 hours. R1 admitted to the facility on June 17, 2024, with diagnoses including paraplegia (paralysis of the legs and lower body), attention deficit hypersensitivity disorder (ADHD), chronic pain	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 620	Continued From page 6 syndrome, depression, and anxiety. R1's Service Plan (Waiver) - Addendum to Contract signed June 17, 2024, indicated R1 received services including dressing, bathing, grooming, bowel program, transfers, drinking assistance, medication administration, housekeeping, and laundry. R1's RN (registered nurse) assessment dated September 2, 2024, indicated R1 needed full assistance with bathing, dressing, transfers, and was unable to walk but utilized a power chair independently. R1's progress note dated July 13, 2024, at 6:09 a.m. indicated M-B called the residence around 11:34 p.m. to confirm R1 was in bed, but was informed R1 was not home. M-B texted R1 multiple times without receiving a response. R1 finally texted M-B back at 11:59 p.m. stating, "I'm back." Staff confirmed to M-B that R1 was in the driveway of the residence. The staff on duty encouraged R1 to come inside, but he did not comply. M-B arrived at the residence at 12:46 a.m. to assist with R1's transfer, but R1 was not found. Staff searched the streets and nearby gas stations. 911 was called, and an officer conducted a search by driving around the neighborhood. The last text received from R1 was at 1:28 a.m., stating, "At 6019 15 min." Since then, there has been no further communication via text or phone calls. Consequently, a missing person report was filed with the police, and a copy has been uploaded to his records. R1's progress note dated July 13, 2024, at 9:32 a.m. indicated the morning staff arrived at the residence at 6:30 a.m.; R1 was out of the facility.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 620	Continued From page 7 Around 8:27 a.m., R1 rang the doorbell. When staff opened the door, he asked staff for water to wash his face because he was pepper sprayed. R1 had no shirt on and was wet; staff asked who sprayed him and he said some guys. R1 asked the staff for his medications and breakfast. R1's record did not include evidence a MAARC report had been submitted. R1's progress note dated August 16, 2024, at 10:01 p.m. indicated R1 informed staff at 9:10 p.m. that he was going out and would return to the residence between 7-8:00 a.m. R1 would not tell the staff where he was going when asked. Staff notified LALD-A and M-B. R1's progress note dated August 19, 2024, at 6:03 a.m. (written by M-B) summarized when R1 had left the residence on August 16, 2024, communication attempts and responses with R1 and R1's father, and subsequent return to the licensee on August 19, 2024, at 4:30 a.m. The progress note further indicated R1 had been without his scheduled medications while gone. R1 had been missing for two full days. R1's record did not include evidence a MAARC report had been submitted. On September 16, 2024, at 4:26 p.m. LALD-A stated when R1 leaves the residence for an extended period of time he usually takes his scheduled medications with him. LALD-A further stated when R1 left the residence on August 16, 2024, he did not take his medications with him. LALD-A and M-B stated a MAARC report was not submitted for either of the above incidents. The licensee's 1.16 Vulnerable Adult Policy dated	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 620	Continued From page 8 August 1, 2021, indicated: 2. The assisted living employee has responsibility for the following: f. When abuse or neglect directed toward a vulnerable adult is discovered, the employee is to report the incident in the following manner: 1) Internal Reporting - The employee may make an oral report immediately by phone or otherwise to the director or clinical nurse supervisor - The employee shall be instructed to complete a written report of the abuse and/or neglect within 24 hours. - The clinical nurse supervisor or director will review the situation and investigate to determine if this is a reportable incident, and if so, the information will then be reported/submitted to the MAARC immediately or as soon as possible. - A copy of the report will be sent to the MAARC and a copy will be retained in the clinical record. 3) External Reporting: Any employee may report directly to the MAARC if he/she does not want to report internally. The external report shall be complete/submitted immediately or as soon as possible. The oral report must be followed by a written report. A copy of the written report will be given to the director. The licensee will not retaliate against any employee who reports externally. The licensee's 1.18 Missing Resident policy dated August 1, 2021, indicated: The licensee will immediately investigate any missing resident using an organized approach in order to ensure that if a resident is found to be missing, the appropriate authorities are notified. 8. A vulnerable adult report (MAARC) will be completed.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 620	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, 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) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 660	Continued From page 10 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated July 22, 2024, indicated the licensee was a low risk. ULP-D's employee record indicated a start date of February 2, 2024. On September 17, 2024, at 8:41 a.m. ULP-D was observed administering medication to R1. ULP-D's employee's record contained a QuantiFERON Gold Plus blood test result dated June 1, 2023 (247 days prior to hire). On September 17, 2024, at 2:17 p.m. licensed assisted living director (LALD)-A reviewed ULP-D's employee record and stated the QuantiFERON blood test had been completed greater than 90 days prior to hire. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
0 660	Continued From page 11 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's 4.14 Tuberculosis Screening/Prevention policy reviewed July 22, 2024, indicated: [Licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 12 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1).	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 began receiving assisted living services on June 17, 2024. R1's Service Plan (Waiver) - Addendum to Contract signed June 17, 2024, indicated R1 received services including dressing, bathing, grooming, bowel program, transfers, drinking assistance, medication administration, housekeeping, and laundry. R1's hospital discharge report dated August 31, 2024, indicated R1 was hospitalized on August 25, 2024, and returned to the licensee on August 31, 2024. R1's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 14 housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On September 17, 2024, at 8:17 a.m. licensed assisted living director (LALD)-A stated the licensee had not been providing a written relocation notice to any residents who were hospitalized nor was the Office of Ombudsman for Long-Term Care being notified if a resident had not returned within four days. LALD-A further stated being unaware of the requirement. The licensee's 2.16 Discharge and Transfer of Residents policy dated August 1, 2021, indicated: 25. In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to [licensee name] within four (4) days, the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01620	Continued From page 15	01620		
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) completed a resident assessment within 14 days of admission for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01620	Continued From page 16 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 admitted to the facility on June 17, 2024, with diagnoses including paraplegia (paralysis of the legs and lower body), attention deficit hypersensitivity disorder (ADHD), chronic pain syndrome, depression, and anxiety. R1's Service Plan (Waiver) - Addendum to Contract signed June 17, 2024, indicated R1 received services including dressing, bathing, grooming, bowel program, transfers, drinking assistance, medication administration, housekeeping, and laundry. R1's record included a 14-day assessment dated July 3, 2024 (16 days after initiation of services), thus exceeding 14 calendar days. On September 16, 2024, at 3:29 p.m. clinical nurse supervisor (CNS)-C stated she completed R1's 14-day assessment 16 days after the admission assessment, which was two days late. The licensee's 2.3 Assessment and Reassessment policy dated August 1, 2021, indicated: 6. The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01620	Continued From page 17 (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01640	Continued From page 18 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: On September 17, 2024, at approximately 10:40 a.m. clinical nurse supervisor (CNS)-C was observed providing wound care to R1's coccyx. R1 admitted to the facility on June 17, 2024, with diagnoses including paraplegia (paralysis of the legs and lower body), attention deficit hypersensitivity disorder (ADHD), chronic pain syndrome, depression, and anxiety. R1's hospital discharge report dated August 31, 2024, indicated R1 was hospitalized on August 25, 2024, and returned to the licensee on August 31, 2024. R1's discharge orders included daily wound care to a coccyx wound. R1's Service Plan (Waiver) - Addendum to Contract signed June 17, 2024, indicated R1 received services including dressing, bathing, grooming, bowel program, transfers, drinking assistance, medication administration, housekeeping, and laundry. The service plan did not include R1's daily wound care. On September 17, 2024, at 10:19 a.m. CNS-C stated R1's service plan was not revised when the resident developed a coccyx wound and wound care treatment was initiated. The licensee's 1.7 Service Plan policy dated August 1, 2021, indicated: 3. The service plan must be revised, if needed,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01640	Continued From page 19 based on resident review or reassessment. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01700	Continued From page 20 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R1) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 16, 2024, at 11:39 a.m. clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to the residents of the facility. R1 admitted to the facility on June 17, 2024, with diagnoses including paraplegia (paralysis of the legs and lower body), attention deficit hypersensitivity disorder (ADHD), chronic pain syndrome, neurogenic bowel and bladder, deep vein thrombosis (DVT-blood clot) of left lower extremity, depression, and anxiety. R1's Service Plan (Waiver) - Addendum to Contract signed June 17, 2024, indicated R1 received services including medication administration. R1's prescriber orders signed August 31, 2024,	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01700	Continued From page 21 included the following medications: one antidepressant, one blood thinner, three muscle relaxants, three supplements, and three for constipation. R1's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, R1's record did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On September 16, 2024, at 3:29 p.m. CNS-C reviewed R1's initial medication management assessment dated June 17, 2024, and stated the required content as noted above had not been included in the assessment. The licensee's 3.2 Assessment of Medications policy dated August 1, 2021, indicated: 1. The RN will provide and document a face-to-face assessment with the resident. 2. The assessment includes the following elements. a. Identification of all medications, including over-the-counter and herbal/dietary supplements b. Medication reconciliation i. Identification of the most accurate list of all medications the resident is taking, including the name, dosage, frequency and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber of other provider. ii. Assessment of the following: 1. Indication for medications 2. Effectiveness of drug therapy	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01700	Continued From page 22 3. Side effects 4. Immediate desired effects 5. Unusual and expected effects 6. Actual or potential drug interactions 7. Duplicate drug therapy 8. Non-adherence with drug therapy 9. Drug therapy currently associated with laboratory monitoring 10. Allergic reactions 11. Changes in condition that contraindicate continued administration of the medication 12. Any difficulties with taking the medication 12. Resident preferences in how to take medications c. Intervention needed in management of medications to prevent the potential for diversion of medications by the resident or others with access to it. The resident and resident's legal or designated representatives will be educated regarding interventions to manage the medications and prevent diversion. The risk (high, moderate or low risk) for diversion will be measured according to the following criteria i. Controlled substances being used by resident ii. Presence of other residents or visitors to home with access to medications iii. Other risk factors/lack of protection of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01730	Continued From page 23	01730		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01730	Continued From page 24 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 16, 2024, at 11:39 a.m. clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to the residents of the facility. On December 17, 2024, unlicensed personnel (ULP)-D was observed administering medications to R1. R1 admitted to the facility on June 17, 2024, with diagnoses including paraplegia (paralysis of the legs and lower body), attention deficit hypersensitivity disorder (ADHD), chronic pain syndrome, neurogenic bowel and bladder, deep	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01730	Continued From page 25 vein thrombosis (DVT-blood clot) of left lower extremity, depression, and anxiety. R1's Service Plan (Waiver) - Addendum to Contract signed June 17, 2024, indicated R1 received services including medication administration. R1's prescriber orders signed August 31, 2024, included the following medications: one antidepressant, one blood thinner, three muscle relaxants, three supplements, and three for constipation. R1's individual medication management plan lacked: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On September 16, 2024, at 3:29 p.m. CNS-C stated R1 did not have a medication	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01730	Continued From page 26 management plan with all required content included in the resident's record. The licensee's 3.3 Service Plan for Medication Management policy dated August 1, 2021, indicated: 1. The written Medication Management Plan includes the following provisions. a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the resident assessment and addressing i. Resident preference ii. Risk of diversion iii. Instructions per manufacturer c. Documentation procedures d. Procedures for medication reconciliation e. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely f. Description of medication management tasks to be delegated to unlicensed personnel g. Plans for staff notifying the licensed health professional when/if a problem with medications management services arises h. Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 27	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 28 resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 16, 2024, at 11:39 a.m. clinical nurse supervisor (CNS)-C stated the licensee provided treatment management services to residents, including wound care. R1's hospital discharge orders dated August 31, 2024, included: Daily wound care to coccyx wound: a. Cleanse with normal saline, pat dry b. Cavilon skin prep to periwound skin c. Pack the 1/4" Nu Gauze moistened with 0.125% Dakins d. Cover with Mepilex R1's Services Delivered record from September 3, 2024, to September 16, 2024, included wound care every morning. On September 17, 2024, at 10:19 a.m. CNS-C stated a home care wound nurse initially came to the residence to perform R1's wound care upon discharge from the hospital. R1 refused to continue the service by the home care nurse, and the licensee took over providing the wound care treatment. CNS-C reviewed R1's wound care	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 29 treatment plan and stated it did not include direction to staff of when to notify a nurse when problems arose with R1's coccyx wound. The licensee's 2.13 Treatment and Therapy Management policy dated August 1, 2021, indicated: 6. The RN (registered nurse) or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy service, which addresses: a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02310	Continued From page 30 by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for one of one resident (R1) with a bed rail. 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: On September 17, 2024, at 8:47 a.m. R1 was observed lying in bed during medication administration. R1's bed had bilateral hospital bed rails; the rail on the exit side of the bed was in the raised position. R1 was observed using the bed rail to aid with positioning. R1 admitted to the facility on June 17, 2024, with diagnoses including paraplegia (paralysis of the legs and lower body), attention deficit hypersensitivity disorder (ADHD), chronic pain syndrome, depression, and anxiety. R1's Service Plan (Waiver) - Addendum to Contract signed June 17, 2024, indicated R1 received services including dressing, bathing, grooming, bowel program, transfers, drinking assistance, medication administration, housekeeping, and laundry. R1's recent assessment dated September 2,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02310	Continued From page 31 2024, did not include measurements of the bed rail zones of entrapment. R1's prior assessments were reviewed and did not include measurements of the bed rail zones of entrapment. On September 16, 2024, at 3:29 p.m. CNS-C stated she had assessed R1's bedrails; however, she did not measure the bed rail zones of entrapment as required. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02310	Continued From page 32 - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's 2.8 Side Rail Use policy dated August 1, 2021, indicated: 8. The RN is responsible to ensure that the side rails in use are of a safe design and properly maintained. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02320	Continued From page 33 care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of one resident (R1) observed during medication administration. 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's diagnoses included, paraplegia (paralysis of the legs and lower body), attention deficit hypersensitivity disorder (ADHD), chronic pain syndrome, neurogenic bowel and bladder, deep vein thrombosis (DVT-blood clot) of left lower extremity, depression, and anxiety. R1's Service Plan (Waiver) - Addendum to Contract signed June 17, 2024, indicated R1 received services including medication administration. On September 17, 2024, at 8:47 a.m. unlicensed personnel (ULP)-D was observed setting up	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02320	Continued From page 34 medications to administer for R1. Eight of R1's oral medications had been set up by the pharmacy in one blister package. The package listed the name and dosage of each medication on the top of the blister package. ULP-D opened the blister package and poured the eight medications into a medication cup without comparing what was listed on the top of the package with R1's medication administration record (MAR). ULP-D then set-up R1's one narcotic medication (Lyrica-for nerve pain) that was supplied on 28-day blister cards. ULP-D popped one scheduled Lyrica capsule into the medication cup. ULP-D then opened up R1's MAR on the computer and clicked on each AM medication that it had been verified; although he had not compared the prescription labels with the orders in the MAR. ULP-D also recorded the number of Lyrica remaining on the MAR; although he had not physically counted the medication. The surveyor asked ULP-D how he knew the amount of Lyrica remaining without counting them. ULP-D stated he had counted that medication at the beginning of his shift and had not administered any since, so he knew there was one less than when he counted earlier. ULP-D did not count the narcotic medication until prompted by the surveyor. ULP-D then administered the medications to R1. Immediately following administration, ULP-D returned to the computer and clicked on each AM medication indicating he had administered the medication. On September 17, 2024, at 9:32 a.m. clinical nurse supervisor (CNS)-C stated she would expect staff to count controlled medications at change of shift and each time one was administered. CNS-C further stated she would expect staff to compare residents' medication labels with the orders in the MAR when setting up	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36155	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	6019 COLFAX AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02320	Continued From page 35 medications for administration. The licensee's Medication Administration policy dated August 1, 2021, indicated: 6. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate f. Side effects g. Resident allergies to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *09/16/24*
Time: 12:00:00
Report: 1051241113

Food and Beverage Establishment Inspection Report

Location:

Care Plus Home Care Llc
6019 Colfax Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:

ID #: 0037476
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632964660
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

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

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

MET WITH NURSE EVALUATOR, WENDY BUCKHOLZ.

DISCUSSED THE FOLLOWING WITH THE DIRECTOR, GAIL:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE

THE KITCHEN HAS LAMINATE COUNTERTOPS WITH HOLLOW BASES, VINYL WOODEN FLOORS, SMOOTH TEXTURE CEILING, MDF WOODEN CABINETS, AND A HIGH TEMPERATURE DISHWASHER.

Type: Full
Date: *09/16/24*
Time: 12:00:00
Report: 1051241113
Care Plus Home Care Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241113 of 09/16/24.

Certified Food Protection Manager: Micah H. Ngafua

Certification Number: FM123861 Expires: 06/26/27

Inspection report reviewed with person in charge and emailed.

Signed:_____
Gail Ngafua

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us