Electronically Delivered

December 3, 2024

Licensee
Skyblu Residential Services
9121 Barrington Terrace
Brooklyn Park, MN  55443

RE: Project Number(s) SL36058015

Dear Licensee:

On October 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 21, 2024, survey were corrected. 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,

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

JMD

Electronically Delivered

September 20, 2024

Licensee
SkyBlu Residential Services
9121 Barrington Terrace
Brooklyn Park, MN  55443

RE:  Project Number(s) SL36058015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 21, 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.

**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.

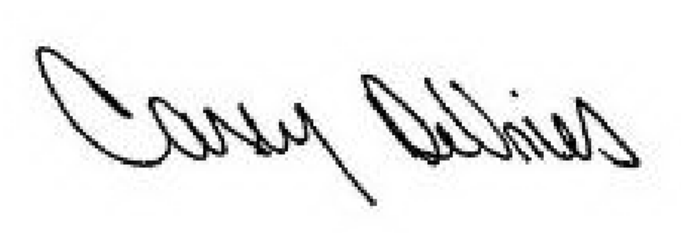
To submit a reconsideration request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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 |
|---|---|---|---|
| | 36058 | A. BUILDING: _____ B. WING _____ | 08/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SKYBLU RESIDENTIAL SERVICES | 9121 BARRINGTON TERRACE BROOKLYN PARK, MN 55443 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>SL36058015-0<br><br>On August 19, 2024, through, August 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents all of whom received services under the provider's Assisted Living license.<br><br>An immediate correction order was identified on August 20, 2024, issued for SL36058015-0, tag identification 0495. | 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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br>The findings include:<br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 490 SS=F | 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements<br><br>(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for | 0 490 | | |

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| 0 490 | Continued From page 2<br><br>providing this assistance;<br>(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;<br>(vi) provide culturally sensitive programs; and<br>(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On August 19, 2024, and August 21, 2024, the surveyor did not observe any activities planned or offered to the residents. | 0 490 | | |

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| 0 490 | Continued From page 3<br><br>On August 19, 2024, at 10:19 a.m., project manager (PM)-D stated the licensee provided culturally sensitive programs including a daily program of social and recreational activities.<br><br>On August 19, 2024, at 11:30 a.m., during a tour of the facility, the surveyor observed there was not an activity calendar posted in any part of the facility.<br><br>On August 19, 2024, between 10:33 a.m., and 12:20 p.m., the surveyor observed R5 made frequent trips outside to the patio to smoke and back to the lower living room to watch television and remained there the whole time.<br><br>On August 19, 2024, at 12:31 p.m., the surveyor observed R4 pace up and down doing circles in the living room unengaged.<br><br>On August 21, 2024, at 1:20 p.m., licensed assisted living director (LALD)-B stated the licensee's residents were slow in the morning but later in the day they were more alert to participate in activities. PM-D stated they had posted the activities calendar.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 490 | | |
| 0 495 SS=F | 144G.41 Subd. 1 (14) Minimum Requirements<br><br>(14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week<br><br>This MN Requirement is not met as evidenced | 0 495 | | |

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| 0 495 | Continued From page 4<br>by:<br>Based on interview and record review, the licensee failed to ensure staff had access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This affected all residents and staff.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On August 19, 2024, at 10:19 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they were the only RN working for the licensee. CNS-A stated they also worked a full-time night shift job as a nursing supervisor at a different facility not associated with the licensee. CNS-A stated their shift started at 10:30 p.m. and ended at 7:00 a.m., and they worked nine days per two-week pay period. CNS-A stated they typically received a phone call or a text message from the licensee's unlicensed personnel (ULP) and then they called them back. CNS-A stated occasionally they take direct patient care assignments during their shift if the other facility was short staffed. CNS-A also stated if they received a call and they were on a direct care patient assignment or needed to come to the house (licensee's facility) they would need to call their supervisor (at their other job) to inform them of the need to go to attend to an emergency before leaving, or they would inform the licensee's ULP to call 911. CNS-A stated if a | 0 495 | | |

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| 0 495 | Continued From page 5<br><br>resident was ready to be readmitted to the licensee's facility from the hospital after hours or during the night, they would call the hospital to hold the discharge to the next day when they were available to complete a readmission.<br><br>On August 19, 2024, at 10:19 a.m., program manager (PM)-D stated the licensee had a contract for nursing services from an outside agency in case CNS-A was not available. However, they had never utilized the agency staff since the contract was signed.<br><br>On August 20, 2024, at 10:20 a.m., CNS-A stated if staff called and they were not able to reach them, staff would call the licensed assisted living director (LALD), who is not a RN. CNS-A also stated that it was only LALD, CNS, or the program manager (PM) who would call the outside agency in case of need, and that licensee had never called the agency for a backup RN when RN-A was doing a direct patient care shift at their other job. When the surveyor requested to know if CNS-A had ever taken a vacation, CNS-A stated they take vacations, but they were accessible through their phone in case of emergency.<br><br>On August 20, 2024, at 10:38 a.m., when the surveyor requested how often CNS-A took direct patient care responsibilities in a month, CNS-A stated they rarely did direct patient care shifts, but stated they picked up at least one patient care shift in the last month.<br><br>On August 20, 2024, at 1:30 p.m., the surveyor attempted to call ULP-E who worked nights but did not reach them and did not receive a call back by the time the immediate order for correction was issued. | 0 495 | | |

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| 0 495 | Continued From page 6<br><br>The licensee's Staffing and Scheduling policy dated August 1, 2021, did not address RN availability.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate | 0 495 | | |
| 0 630 SS=D | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 | 0 630 | | |

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| 0 630 | Continued From page 7<br><br>a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2 was admitted to the licensee and began receiving assisted living services on December 5, 2023.<br><br>R2's diagnoses included schizoaffective disorder, anorexia nervosa, borderline personality disorder, and chronic post-traumatic stress disorder (PTSD).<br><br>R2's Individual Abuse Prevention Assessment and Plan dated December 5, 2023, indicated R2 had the following vulnerabilities: eating disorder and history of sexual abuse.<br><br>R2's IAPP failed to address R2's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse to others.<br><br>On August 21, 2024, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated R2 was not a risk of abusing others, but they missed including that in R2's IAPP.<br><br>The licensee Vulnerable Adult policy dated August 1, 2021, indicated the resident's risk of abusing other vulnerable adults within the residence shall be assessed. Also indicated the vulnerable adult status assessment shall be documented in the clinical record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |

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

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| 0 680 | Continued From page 9<br><br>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).<br><br>The findings include:<br><br>The licensee's undated, emergency preparedness plan lacked the following required content:<br>- subsistence needs for staff and patients (residents);<br>- procedures for tracking of staff and patients;<br>- policies and procedures including evacuation;<br>- policies and procedures for medical documents;<br>- policies and procedures for volunteers;<br>- roles under a waiver declared by secretary;<br>- primary/alternate means for communication;<br>- methods for sharing information;<br>- sharing information on occupancy/needs; and<br>- LTC family notifications.<br><br>On August 21, 2024, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated the licensee was still working on updating their EPP to be compliant with state requirements.<br><br>The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |

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| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the proper installation of the portable fire extinguishers. This had the potential to directly affect residents and staff.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On August 20, 2024, from 12:45 p.m. to 2:00 p.m., survey staff toured the home with the program manager (PM)-D. During the tour, survey staff observed the following: | 0 790 | | |

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| 0 790 | Continued From page 11<br><br>-A portable fire extinguisher (PFE) in the laundry room was incorrectly mounted at a height of 57 inches above the floor and located behind the laundry sink preventing readily and immediate access for use during an emergency. The PM-D verified the findings and stated that they would relocate the PFE and install the signage on the door to the laundry room to show the location of the PFE.<br><br>-A PFE unit was incorrectly mounted in the middle of the stairway between the main and upper-level floor at a height of approximately 57 inches above the floor and the stairway incline location preventing ready and immediate access.<br><br>During an interview survey staff explained to the PM-D the maximum height allowed by the state standard (for extinguishers weighing less than 40 pounds) must be 60 inches (5 feet) above the floor and must be readily accessible. The PM-D verified the findings at the time of discovery and stated that it made sense.<br><br>On August 20, 2024, at approximately 3:30 p.m., during the exit interview, survey staff explained the above deficient findings to the licensed assisted living director-B and the PM-D, they understood and acknowledged the findings. The PM-D stated they would relocate the PFE in the laundry room and the PFE unit on the steps to the end of the upper-level hallway.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |

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| 0 800 | Continued From page 12 | 0 800 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On August 20, 2024, from 12:45 p.m. to 2:00 p.m., survey staff toured the home with the program manager (PM)-D. During the tour, survey staff observed the following:<br><br>-Improper disposal of cigarette butts discarded in containers and on the ground in the patio area | 0 800 | | |

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| 0 800 | Continued From page 13<br><br>when an approved cigarette butt receptacle was provided for proper disposal. The PM-D verified the finding but did not comment.<br>-A cover on an exterior electrical duplex outlet next to the garage was damaged exposing the electrical receptacle to potential water during rainfall.<br>-The exhaust fan cover in the upper-level bathroom was covered with thick dust. The PM-D agreed to clean out the fan cover.<br>-The resident sleeping room 5 egress encasement window was obstructed by the exterior window well cover. The window opened to 13 inches and would not open completely due to the obstruction. The PM-D verified the finding and stated they fixed the window well cover to eliminate the obstruction.<br>- The home's water and gas shut-off (control) valves along with appliances and food storage shelves were located in a mechanical room where the staff must enter a resident bedroom (5) on the lower-level floor to access, preventing ready access required during an emergency. Survey staff explained to the PM-D that access to shut-off valves must be available for staff-ready access at all hours of the day including evening hours. The above deficient finding was verbally and visually verified by the PM-D at the time of discovery.<br>-The door to resident room 3 located on the upper-level floor did not have any privacy hardware provision. Survey staff explained to the PM-D that privacy provisions must be made for resident room 3. During an interview at approximately 2:00 p.m.,, the licensed assisted living director (LALD-B) explained that the resident in room 3 had clinical conditions and did not want to install a privacy lock hardware that would allow staff ready access to assist the resident from any harm quickly. When survey | 0 800 | | |

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| 0 800 | Continued From page 14<br><br>staff asked about physician documentation to substantiate the condition, the LALD-B did not have documentation. The LALD-B further stated they could install a basic push button doorknob privacy lock.<br>-Door hasps were installed on the doors to resident rooms 2 and 3 on the hallway side. The PM-D stated they were used when the rooms were vacant and would remove them.<br><br>The above deficient findings were verbally and/or visually verified by the PM-D at the time of discovery.<br><br>On August 20, 2024, at approximately 3:30 p.m., during the exit interview, survey staff explained the above deficient findings to the LALD-B and the PM-D, they understood and acknowledged the findings and did not have any further questions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, | 0 810 | | |

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| 0 810 | Continued From page 15<br><br>evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the required number of fire evacuation drills to cover all work shifts, and the required minimum training of staff on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a | 0 810 | | |

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| 0 810 | Continued From page 16<br><br>widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On August 20, 2024, from 12:45 p.m. to 2:00 p.m., survey staff toured the home with the program manager (PM)-D. During the tour, survey staff observed the door through the laundry room and to the garage incorrectly labeled the garage as an approved exit route. The signs were removed immediately during the tour. The deficient finding was verified by the PM-D.<br><br>On August 20, 2024, at approximately 3:15 p.m. document and record review and interview with the licensed assisted living director (LALD)-B, on the home's fire safety and evacuation plan, titled Fire Safety Policy, dated August 1, 2021, and related training policies, procedures, and records indicated the following:<br><br>-Document review indicated the licensee's fire safety and evacuation plan did not include specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the LALD-B verified that the fire safety and evacuation plan did not include these provisions.<br><br>-A record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the initial hire training. Survey staff explained that the record review indicated one employee training on fire | 0 810 | | |

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| 0 810 | Continued From page 17<br><br>safety and evacuation training was provided in 2022 and one in 2023. Employee training on fire safety and evacuation must be performed twice a year. During an interview, the LALD-B verified that the training was incomplete.<br><br>-A record review of the available documentation indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per shift per year with at least one evacuation drill every other month. Record review indicated that three evacuation drills were conducted in 2024 to date, with all drill records noting "A.M." in 2024, and no other records were available or provided to show the drills for the other two work shifts. Survey staff explained to the LALD-B that the evacuation drills did not cover all work shifts and they would need to start the employee fire evacuation drills as soon as possible that meet 1) twice per shift per year, and 2) at least one evacuation drill every other month for a total of six evacuation drills per year.<br><br>The above deficient findings were verified by the LALD-B and PM-D during the interview.<br><br>On August 20, 2024, at approximately 3:30 p.m., during the exit interview, survey staff explained the above deficient findings to the licensed assisted living director-B and the PM-D, and they acknowledged the findings.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 910 SS=C | 144G.50 Subd. 2 (a-b) Contract information | 0 910 | | |

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| 0 910 | Continued From page 18<br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.<br>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:<br>(1) the facility and contracted service provider when applicable;<br>(2) the licensee of the facility;<br>(3) the managing agent of the facility, if applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract with the required content for all licensee's residents. This had the potential to affect all residents living in the assisted living facility.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On August 19, 2024, at 1:15 a.m., clinical nurse supervisor (CNS)-A provided the surveyor with the licensee's blank contract and stated the same contract was given to all the licensee's residents.<br><br>The licensee's Assisted Living Contract lacked documentation of the Health Facility Identification | 0 910 | | |

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| 0 910 | Continued From page 19<br>(HFID) number of the facility in a conspicuous place and manner.<br><br>On August 19, 2024, at 2:30 p.m., CNS-A stated licensee was not aware of the requirement and all resident contracts would be missing the HFID number.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 910 | | |
| 0 970 SS=C | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive | 0 970 | | |

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| 0 970 | Continued From page 20<br><br>or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On August 19, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-A provided the surveyor with licensee's blank contract, and stated the same was used by all licensee's residents. The contract had two sections with language waiving the licensee's liability for health, safety, or personal property of a resident.<br><br>The licensee's Assisted Living Contract read, under section miscellaneous provisions "the resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee] or its employees or agents."<br>Under section indemnification: "[licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]."<br><br>On August 19, 2024, at 11:45 a.m., CNS-A stated | 0 970 | | |

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| 0 970 | Continued From page 21<br><br>the licensee was not aware of the liability clause in their contract, and all of the resident contracts had liability language in them.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01470 SS=F | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human | 01470 | | |

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| 01470 | Continued From page 22<br><br>Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for one of one employee (unlicensed personnel (ULP)-C).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a | 01470 | | |

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| SKYBLU RESIDENTIAL SERVICES | 9121 BARRINGTON TERRACE BROOKLYN PARK, MN 55443 |

| (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 |
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| 01470 | Continued From page 23<br><br>widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ULP-C started employment with the licensee July 14, 2021, under the former comprehensive license and started providing assisted living services on August 1, 2021.<br><br>ULP-C's employee record lacked the following required orientation content:<br>- overview of assisted living statutes;<br>- review of provider's policies and procedures;<br>- assisted living bill of rights; and<br>- principles of person-centered planning/service delivery.<br><br>On August 20, 2024, at 2:35 p.m., ULP-C stated they received training and orientation with they started working for the licensee but could not remember the topics that were covered.<br><br>On August 20, 2024, at 2:38 p.m., clinical nurse supervisor (CNS)-A stated the licensee missed training on some topics because the forms they used were from the time they held a comprehensive license. CNS-A stated it was likely more staff would be missing the same topics as the same training manual was used for their orientation.<br><br>The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through [licensee] will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the | 01470 | | |

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| 01470 | Continued From page 24<br>residents. The policy included all the topics missing above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01500 SS=F | 144G.63 Subd. 5 Required annual training<br><br>(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:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(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;<br>(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 disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services | 01500 | | |

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| 01500 | Continued From page 25<br><br>and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(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:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure all staff that perform direct services completed at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a | 01500 | | |

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| 01500 | Continued From page 26<br><br>widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ULP-C started employment with the licensee July 14, 2021, under the former comprehensive license and started providing assisted living services on August 1, 2021.<br><br>ULP-C's employee record lacked the following required annual training topics:<br>- review of provider's policies and procedures; and<br>- principles of person-centered planning/service delivery.<br><br>On August 20, 2024, at 2:35 p.m., ULP-C stated they had completed annual training.<br><br>On August 20, 2024, at 2:38 p.m., clinical nurse supervisor (CNS)-A stated the licensee missed training on some topics because the forms they used were from the time they held a comprehensive license. CNS-A stated it was likely more staff would be missing the same topics as the same training manual was used for annual training.<br><br>The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated annual education may include training on providing services to residents with hearing loss. The policy lacked the required annual training topics.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 01500 | | |

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| 01500 | Continued From page 27<br>(21) days | 01500 | | |
| 01530 SS=F | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) received eight hours of initial dementia care training within the first 160 working hours of the employment start | 01530 | | |

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| 01530 | Continued From page 28<br>date.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ULP-C started employment with the licensee July 14, 2021, under the former comprehensive license and started providing assisted living services on August 1, 2021.<br><br>ULP-C's Orientation Tracking dated July 15, 2021, indicated ULP-C completed the following topics for a blanket eight hours of training;<br>- a current explanation of Alzheimer's disease and related disorders;<br>- effective approaches to use to problem-solve when working with residents with challenging behaviors; and<br>- how to communicate with residents who have Alzheimer's or related disorder.<br><br>ULP-C's employee record lacked the required initial dementia training in the following topics:<br>- assistance with activities of daily living; and<br>- person-centered planning and service delivery.<br><br>On August 20, 2024, at 10:38 a.m., clinical nurse supervisor (CNS)-A stated the licensee's training manual had only the three topics. Also, CNS-A stated the licensee was not sure of the required dementia training topics. CNS-A stated all the employees would have the same blanket eight | 01530 | | |

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| 01530 | Continued From page 29<br><br>hours and would be lacking the same topics above.<br><br>The licensee's Dementia Education policy dated August 1, 2021, indicated all staff providing care in [licensee] will be knowledgeable in how to provide safe, effective services related to dementia. The policy also indicated all the missing topics will be included in the training.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01620 SS=F | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(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.<br>(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 | 01620 | | |

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| 01620 | Continued From page 30<br><br>prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments not to exceed 90 calendar days from the last date of the assessment for two of two residents (R2, R4).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R2<br>R2 was admitted to the licensee on December 5, 2023, and began to receive assisted living services.<br><br>R2's Service Plan signed dated December 5, 2023, indicated R2 received assistance with bathing, medication management, grooming, dressing, home management, food preparation, mental health management, and shopping.<br><br>R2's record included a 14-day assessment completed on December 19, 2023, and two ongoing 90-day assessments completed on March 5, 2024, and June 5, 2024. The June 5, 2024, assessment was completed late by two | 01620 | | |

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| 01620 | Continued From page 31<br>days.<br><br>R4<br>R4 was admitted to the licensee on September 14, 2023, and began to receive assisted living services.<br><br>R4's Service Plan signed dated September 14, 2023, indicated R4 received assistance with bathing, medication management, clinical monitoring, grooming, dressing, home management, food preparation, mental health management, and shopping.<br><br>R4's record included a 14-day assessment completed on December 14, 2023, and two ongoing 90-day assessments completed on March 14, 2024, and June 14, 2024. The June 14, 2024, assessment was completed late by two days.<br><br>On August 21, 2024, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated they attributed the late assessments to their system of counting days. Also, CNS-A stated they were not aware the assessments were completed late as they marked their calendars after counting 90 days physically.<br><br>The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |

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| 01760 | Continued From page 32 | 01760 | | |
| 01760 SS=D | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to administer medication according to provider orders for one of two residents (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>R2's Service Plan signed and dated December 5, 2023, indicated R2 received assistance with | 01760 | | |

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| 01760 | Continued From page 33<br><br>bathing, medication management, grooming, dressing, home management, food preparation, mental health management, and shopping.<br><br>R2's electronic medication administration record (eMAR) dated August 1, 2024, through August 20, 2024, indicated R2 was taking the following medications: multi vitamin take one tablet by mouth daily, vitamin D 1000 units tablets take one tablet by mouth once daily, mirtazapine 15 milligram (mg) take one tablet by mouth at bedtime, and quetiapine 100 mg take one- and one-half tablet by mouth at bedtime, and fluticasone 50 microgram (mcg) inhale one spray into affected nostril as needed two times daily. The eMAR indicated the fluticasone was not administered through the period reviewed.<br><br>R2's provider orders electronically signed on December 18, 2023, indicated fluticasone propionate 50 mcg actuation nasal spray inhale one spray into affected nostril two times daily. The order did not indicate the medication was for use as needed.<br><br>On August 21, 2024, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated R2 went to see their provider and came back with a new order to administer fluticasone propionate 50 mcg as needed. When the surveyor requested for the order, CNS-A stated they were unable to find it and that they would call the provider for a new order.<br><br>The licensee's Medication Incidents/Errors policy dated August 1, 2021, indicated [licensee] will recognize and promptly address medication errors/incidents. Medication errors/incidents will be monitored and tracked through the organization's performance improvement | 01760 | | |

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| 01760 | Continued From page 34<br>program.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01940 SS=F | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>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:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(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 | 01940 | | |

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| 01940 | Continued From page 35<br>changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to include all treatments or therapies ordered on the service plan for one of one resident (R2) with blood glucose management.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R2's diagnoses included schizoaffective disorder, depressed type, Anorexia nervosa, borderline personality disorder, and bipolar.<br><br>R2's Service Plan (SP) signed and dated December 5, 2023, indicated R2 received assistance with bathing, medication management, grooming, dressing, home management, food preparation, mental health management, and shopping.<br><br>R2's Treatment Administration Record (TAR) dated between August 1, 2024, and August 20, 2024, indicated R2 received blood glucose monitoring three times daily before meals. R2's blood glucose monitoring results ranged between 82 milligrams per deciliter (mg/dL) and 136 mg/dL. | 01940 | | |

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| SKYBLU RESIDENTIAL SERVICES | 9121 BARRINGTON TERRACE BROOKLYN PARK, MN 55443 |

| (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 36<br><br>R2's provider orders electronically signed on December 18, 2023, indicated freestyle libre 2 reader to be used for blood sugars per manufacturer's direction.<br><br>On August 21, 2024, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated they did not know it was required to include all treatments or therapies on R2's service plan.<br><br>The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated registered nurse or licensed health professional is responsible for assessing and developing the treatment and/or therapy service plan for residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |

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

Type: Full
Date: *08/20/24*
Time: 10:00:00
Report: 1005241194

# Food and Beverage Establishment Inspection Report



**Location:**
Astral Home Care Llc
9121 Barrington Terrace
Brooklyn Park, MN55443
Hennepin County, 27

**Establishment Info:**
ID #: 0039089
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7632839973
ID #:

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

The following orders were issued during this inspection.

**3-500A Microbial Control: cooling**

***3-501.14A*** ***** Priority 1 *****

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

LEFTOVER RICE FROM YESTERDAY WAS STILL 46 DEGREES F. DISCUSSED THE DANGERS OF IMPROPER COOLING, AND THAT FACILITY SHOULD ONLY BE MAKING FOOD FOR SAME DAY SERVICE BECAUSE THEY HAVE RESIDENTIAL EQUIPMENT. RICE WAS DISCARDED.

*Comply By: 08/20/24*

**3-500B Microbial Control: hot and cold holding**

***3-501.16A2*** ***** Priority 1 *****

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

TCS FOODS IN THE "MAGIC CHEF" REFRIGERATOR WERE ABOVE 41 DEGREES F. THE FRIDGE WAS ADJUSTED TO A COLDER SETTING. MONITOR TEMPERATURES TO ENSURE THEY COME TO 41 DEGREES F OR BELOW.

*Comply By: 08/20/24*

**3-500C Microbial Control: date marking**

***3-501.17B*** ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPENED CONTAINERS OF MILK AND LETTUCE WERE NOT DATE-MARKED. DISCUSSED MARKING FOODS WITH THE DATE THEY ARE OPEN TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS. FACT SHEET LEFT ON SITE.

*Comply By: 08/20/24*

**4-200 Equipment Design and Construction**

***4-201.11GMN***

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

LEFTOVER RICE FROM YESTERDAY HAD BEEN SAVED, AND WAS COOLED IMPROPERLY. RICE WAS DISCARDED. TCS FOODS SHOULD BE PREPARED FOR SAME-DAY SERVICE ONLY.

*Comply By: 08/20/24*

**4-500 Equipment Maintenance and Operation**

***4-501.11AB***

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE DISHWASHER IS BROKEN AND STAFF HAVE BEEN WASHING, RINSING, AND SANITIZING DISHES IN THE 2-COMPARTMENT SINK. A NEW DISHWASHER HAS BEEN ORDERED AND SHOULD BE INSTALLED IN THE COMING DAYS.

*Comply By: 09/20/24*

**6-300 Physical Facility Numbers and Capacities**

***6-301.14A***

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

NO HANDWASHING SIGN IS POSTED AT THE KITCHEN HAND SINK. SIGN LEFT ON SITE.

*Comply By: 08/20/24*

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

***6-501.11***

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE FLOORING IN FRONT OF THE DISHWASHER IS DAMAGED AND MISSING, DUE TO A LEAK FROM THE DISHWASHER. FACILITY IS WORKING TO HAVE TO REPAIRED.

*Comply By: 11/20/24*

**Food and Equipment Temperatures**

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFIRGERATOR
Violation Issued: No

# Food and Beverage Establishment Inspection Report



Process/Item: Cold Hold/LETTUCE
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/PICKLES
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cooling/RICE
Temperature: 46 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Process/Item: Cold Hold/MILK
Temperature: 44 Degrees Fahrenheit - Location: MAGIC CHEF REFRIGERATOR
Violation Issued: Yes

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

INSPECTION COMPLETED WITH FOOD MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR BENARD NYANGENA.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

SINCE THE DISHWASHER BROKE, STAFF HAVE BEEN WASHING, RINSING AND SANITIZING DISHES IN THE 2-COMPARTMENT KITCHEN SINK. A NEW DISHWASHER SHOULD BE INSTALLED IN THE COMING DAYS.

KITCHEN IS RESIDENTIAL AND FOOD CAN BE PREPARED FOR SAME DAY SERVICE ONLY.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

Type: Full
Date: *08/20/24*
Time: 10:00:00
Report: 1005241194
Astral 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 1005241194 of 08/20/24.

Certified Food Protection Manager: LATIA C. CASTILLEJA

Certification Number: FM117979 Expires: 07/13/26

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

Signed: _____
LATIA CASTILLEJA

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us

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

Type: Follow-Up
Date: *08/26/24*
Time: 15:26:32
Report: 1005241197

# Food and Beverage Establishment Inspection Report



**Location:**
Astral Home Care Llc
9121 Barrington Terrace
Brooklyn Park, MN55443
Hennepin County, 27

**Establishment Info:**
ID #: 0039089
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7632839973
ID #:

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

The following orders previously issued on 08/20/24 have NOT been corrected.

**3-500A Microbial Control: cooling**

***3-501.14A*** ***** Priority 1 *****

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

LEFTOVER RICE FROM YESTERDAY WAS STILL 46 DEGREES F. DISCUSSED THE DANGERS OF IMPROPER COOLING, AND THAT FACILITY SHOULD ONLY BE MAKING FOOD FOR SAME DAY SERVICE BECAUSE THEY HAVE RESIDENTIAL EQUIPMENT. RICE WAS DISCARDED.

*Issued on: 08/20/24* *Comply By: 08/20/24*

**3-500B Microbial Control: hot and cold holding**

***3-501.16A2*** ***** Priority 1 *****

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TCS FOODS IN THE "MAGIC CHEF" REFRIGERATOR WERE ABOVE 41 DEGREES F. THE FRIDGE WAS ADJUSTED TO A COLDER SETTING. MONITOR TEMPERATURES TO ENSURE THEY COME TO 41 DEGREES F OR BELOW.

*Issued on: 08/20/24* *Comply By: 08/20/24*

**3-500C Microbial Control: date marking**

***3-501.17B*** ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPENED CONTAINERS OF MILK AND LETTUCE WERE NOT DATE-MARKED. DISCUSSED

MARKING FOODS WITH THE DATE THEY ARE OPEN TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS. FACT SHEET LEFT ON SITE.

*Issued on: 08/20/24* *Comply By: 08/20/24*

**4-200 Equipment Design and Construction**

***4-201.11GMN***

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

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*Issued on: 08/20/24* *Comply By: 08/20/24*

**6-300 Physical Facility Numbers and Capacities**

***6-301.14A***

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NO HANDWASHING SIGN IS POSTED AT THE KITCHEN HAND SINK. SIGN LEFT ON SITE.

*Issued on: 08/20/24* *Comply By: 08/20/24*

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

***6-501.11***

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE FLOORING IN FRONT OF THE DISHWASHER IS DAMAGED AND MISSING, DUE TO A LEAK FROM THE DISHWASHER. FACILITY IS WORKING TO HAVE TO REPAIRED.

*Issued on: 08/20/24* *Comply By: 11/20/24*

No NEW orders were issued during this inspection.

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

A NEW DISHWASHER HAS BEEN INSTALLED IN THE FACILITY. OPERATOR SENT INSPECTOR A PICTURE OF A TEMPERATURE STRIP THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 160+ DEGREES F.

Type: Follow-Up
Date: *08/26/24*
Time: 15:26:32
Report: 1005241197
Astral 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 1005241197 of 08/26/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

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

Signed:_____
LATIA CASTILLEJA

Signed:_____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us