Electronically Delivered

September 26, 2024

Licensee
Care Partners Homecare LLC
3508 83rd Avenue North
Brooklyn Center, MN 55443

RE: Project Number(s) SL37378015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 28, 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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 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
	37378	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	3508 83RD AVENUE NORTH BROOKLYN CENTER, 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
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: SL# 37378015 On August 26, 2024, through, August 28, 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 four residents receiving services under the provider's Assisted Living Facility 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 27, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650		

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0 650	Continued From page 2 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained required content for one of two employees (clinical nurse supervisor (CNS-C). 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: CNS-C was hired on August 16, 2018, to provide direct care and services to the licensee's residents and oversight of the licensee's	0 650		

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0 650	Continued From page 3 employees. On August 26, 2024, at 10:42 a.m., during the entrance conference, CNS-C identified herself as the CNS for the facility. CNS-C's employee record did not include documentation of all the required training to include: -annual review of provider's policies and procedures. On August 28, 2024, at 10:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated "I" know "we" (licensee) did it (policy review) at the same time as the performance reviews were completed. LALD/RN-A confirmed CNS-C's record did not include required documentation. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a	0 650		

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0 650	Continued From page 4 statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. The licensee's Employee Records policy dated August 1, 2021, noted employee records for each person would include records of all training and in-services education required and/or provided including record of competency testing as requested. Record would include verification of completed orientation and annual training and competency testing as required. The licensee's Annual Required Staff Training policy dated August 1, 2021, noted a training record, kept in employee records would include: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 660		

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0 660	Continued From page 5 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 ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included the completion of baseline TB screenings such as a blood test was completed for one of two employees (unlicensed personnel (ULP)-B). 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: The facility TB risk assessment was dated July 1, 2024. The facility had been identified as low risk. ULP-B was hired on May 24, 2022, to provide	0 660		

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0 660	Continued From page 6 direct care and services to the licensee's residents. On August 26, 2024, at 12:04 p.m., the surveyor observed ULP-B prepare medication for R1 using proper technique. ULP-B's employee record included a completed Baseline TB Screening for Health Care Workers (HCWs) dated May 11, 2022. ULP-B's employee record included a radiologist report dated February 1, 2022, that indicated: -there had been a positive Mantoux test (TB skin test) -lungs clear, no pleural effusion or pneumothorax, no other abnormalities seen. ULP-B's record did not include a IGRA (serum blood test) or TST (first step) dated within 90 days of hire and the x-ray report was dated 99 days prior to ULP-B's hire date. On August 27, 2024, at approximately 3:30 p.m., the surveyor reviewed ULP-B's employee record with licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A stated he thought he had additional records in another location for ULP-B. On August 28, 2024, at 10:01 a.m., LALD/RN-A stated he was not able to locate "anything else" (records) for ULP-B. LALD/RN-A stated to be honest, he looked, but added he has lots of records. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an	0 660		

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0 660	Continued From page 7 employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA or TST (first step) dated within 90 days before hire. The licensee's Tuberculosis Screening policy dated August 1, 2021, noted the licensee would 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 (MMWR). Staffs whose essential job functions require work within the same air space of home care clients would be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening would be completed. Screening would be conducted as follows: -new staff would be screened for active signs of TB using the Baseline Screening Tool for HCWs. -new staff would have an IGRA blood test or a two-step Mantoux conduced with results documented on the Baseline TB Screening Tool for HCWs -no staff would be permitted to begin work where the work involved shared the air space with residents until the negative results of the first Mantoux were read and documented or a negative IGRA blood test result was received and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		

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01750	Continued From page 8	01750		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses include congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs,) obesity, diabetes, shortness of breath and	01750		

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01750	Continued From page 9 schizophrenia ((chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior). R1's service plan dated June 26, 2024, indicated R1 received medication administration. R1's Individualized Medication Management Plan dated June 17, 2024, included: -medication administration by facility staff -insulin administered by the resident per her preference and she is able to demonstrate the ability to administer medications -the client (resident) will keep one of each insulin at the bedside to be administered based on doctor's order. Staff will verify with the client the right amount of insulin and inform RN of anything contrary. R1's medication administration record (MAR) dated August 1, 2024, through August 26, 2024, included: -Novolog 100 units/milliliter (ml) (short acting insulin) pen: 18 units before meals, three times daily plus additional sliding scale: 150-250=three units, 250-350= six units, over 350= nine units. Also, administer five units with bedtime snack -Lantus 100 units/ml (long-acting insulin) pen: 35 units twice daily. R1's prescriber's order dated July 9, 2024, included the above noted medications. On August 26, 2024, at 12:04 p.m., the surveyor observed unlicensed personnel (ULP)-B prepare medication for R1 using proper technique. ULP-B took the medication cup down to R1's room and administered the medication. R1 showed the surveyor how she stored her insulin pens.	01750		

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01750	Continued From page 10 On August 27, 2024, at 11:02 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated, R1's record did not contain specific information such as: R1 self-administered insulin and when to report issues to nursing. On August 28, 2024, at 8:58 a.m., LALD/RN-A stated, "to be honest, instructions are not in any of the resident records." The licensee's Medication & Treatment-Administration & Delegation policy dated August 1, 2021, noted when administration of medications or treatments/therapy is delegated or assigned to unlicensed personnel the licensee would ensure that the registered nurse had specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication 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	01760		

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01760	Continued From page 11 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of two resident (R1) who received medication management services. In addition, the licensee failed to ensure medications were transcribed as prescribed for one of two residents (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: R1's diagnoses include congested heart failure [CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs,] obesity, diabetes, shortness of breath and schizophrenia [chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior]. R1's service plan dated June 26, 2024, indicated R1 received medication administration. On August 26, 2024, at 12:04 p.m., the surveyor observed unlicensed personnel (ULP)-B prepare	01760		

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01760	Continued From page 12 and administer torsemide [CHF/removal of excess fluid] 20 milligrams (mg) to R1 using proper technique. MEDICATION ADMINISTRATION R1's medication administration record (MAR) dated August 1, 2024, though August 26, 2024, included: -torsemide 20 mg twice daily in a.m. (morning) and 1:00 p.m. Take an additional 20 mg daily as needed (PRN) for weight gain of: if overnight, five pounds in one week, swelling or worsening shortness of breath. R1's prescriber's order dated July 9, 2024, included the above medication. On August 27, 2024, at 11:04 a.m., R1's prescriber's order was reviewed with licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A stated R1 was not currently being monitored for weight gain LALD/RN-C stated when you read the order "like that" (as written) R1's torsemide was not being administrated as ordered. MEDICATION TRANSCRIPTION R1's MAR dated August 1, 2024, though August 26, 2024, included, and had been documented as given as noted on MAR: -Chantix (smoking cessation) one mg twice daily -varenicline (Chantix) 0.5 mg twice daily. R1's prescriber's order dated July 9, 2024, included decrease Chantix to 0.5 mg twice daily. On August 27, 2024, at 10:56 a.m., R1's MAR was reviewed with LALD/RN-A. LALD/RN-A stated R1's Chantix medication was a duplication, was a typo and his error, LALD/RN-A said he did	01760		

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01760	Continued From page 13 not remove the "old" order from R1's record (MAR) as required. (two orders for same medication on the current MAR for smoking cessation medication). The licensee's Medication & Treatment Orders policy dated August 1, 2021, noted the RN was responsible for assuring that: -current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the resident's records -changes in orders are addressed in the resident's service plan and are communicated to the other staff -the licensed nurse would review all medication and treatment orders for progress, effectiveness, and necessity on a regular basis and with resident change of condition -a resident's MAR would be audited regularly by licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

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01890	Continued From page 14 Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, at 11:17 a.m., the surveyor reviewed the contents in the locked medication closet with licsensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-C. LALD/RN-A and CNS-C observed and confirmed the following: -one opened Anoro Ellipta inhaler [relaxes muscles in the airways to improve breathing] for R1 -one opened Lantus 100 units/milliliters (ml) [long-acting insulin/diabetes] pen for R3. On August 26, 2024, at 11:36 a.m., CNS-C stated the insulin had been labeled, adding the label must have came off. LALD/RN-A said they need to get a better system and confirmed the Lantus was not dated as required. CNS-C stated R1's Anoro inhaler had a fill date of August 23, 2024, and an expiration date of July 8, 2025.	01890		

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01890	Continued From page 15 On August 26, 2024, at approximately 11:40 a.m., the instructions for Anoro were reviewed with CNS-C. CNS-C confirmed R1's Anoro inhaler was not dated as required. The manufacturer's instructions for Anoro Ellipta dated May 2021, noted write the "try opened" and "discard" dates on the inhaler label. The "discard" date is six weeks from the date you open the tray. The manufacturer's instructions for Lantus pens dated August 2022, noted after 28 days throw your opened Lantus pen away, even if it still had insulin in it. The licensee's Medication Storage policy dated August 1, 2021, noted when medications were managed and stored by (name) medications would be kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the	01950		

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01950	Continued From page 16 registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure instructions, specified in writing for each resident, and documented those instructions in the resident's record for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses include congested heart failure [CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs,] obesity, diabetes, shortness of breath and schizophrenia [chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior]. R1's service plan dated June 26, 2024, indicated R1 received medication administration, oxygen,	01950		

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01950	Continued From page 17 stand by assist with transfers, shower assist, laundry, and housekeeping services. R1's service plan refers to care plans. On August 26, 2024, at 12:04 p.m., the surveyor observed unlicensed personnel (ULP)-B prepare and administer torsemide [CHF/removal of excess fluid] 20 milligrams (mg) to R 1 using proper technique. R1 was lying in a hospital style bed with both side rails in the raised position. The surveyor observed a Libre sensor [measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm] on R1's left upper arm and R1 was wearing a nasal cannula. R1's Individualized Medication Management Plan dated June 17, 2024, included: -the staff will record the client (resident) blood glucose (BG) when the client's BG is taken. -the client (resident) uses Freestyle Libra (FSL) to check her BG and the sensor is changed every 14 days. R1's Individualized Treatment or Therapy Management Plan dated June 17, 2024, included: -BG monitoring: BG is monitored using FSL sensor for diabetes type 2. There is a backup finger stick machine should the sensor on the FSL is [sic] not available or the machine malfunctions. -oxygen management: Staff may adjust cannula/mask position for better delivery of oxygen as necessary and as ordered by my provider and directed by the nurse. The client has a 'trach' [tracheostomy/a surgical opening in a person's neck into the trachea (windpipe) to help the person breathe] dome [collar or mask] connected to trach that she uses at night. She (R1) uses oxygen during the day. The client uses	01950		

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01950	Continued From page 18 trach dome connected to her Jackson trach [type of tube]. The trach dome is used at night, and she uses O2 during the daytime. BLOOD GLUCOSE R1's medication administration record (MAR) dated August 1, 2024, through August 25, 2024, included: -BG check, record the client blood glucose in computer, three times daily, 9:00 a.m., 4:00 p.m., 9:00 p.m. R1's prescriber order dated July 9, 2024, included the above noted treatment/check and record R1's BG. On August 27, 2024, at approximately 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he trained staff [ULPs] to call RN each time a BG is taken. LALD/RN-A said both types of BG testing techniques are taught/trained at the facility and he (LALD/RN-A) would include in R1's record, to use finger poke back up monitoring system LALD/RN-A said there was not specific information in R1's record for BG testing as required. OXYGEN R1's MAR dated August 1, 2024, through August 25, 2024, included: -trach dome connected to humidity and oxygen: tracheostomy tube connected to dome at night for humidity and oxygen, 9:00 a.m., 4:00 p.m., 9:00 p.m. R1's prescriber order dated November 30, 2023, included: -oxygen delivery method: nasal cannula -frequency of use: continuous -liters per minute of continuous oxygen needed:	01950		

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01950	Continued From page 19 three -liters of nocturnal oxygen needed: five. R1's Individual Care Plan dated June 14, 2024, included: tracheostomy. I have an oxygen concentrator in my room for "me (R1) to use while in bed. "I" (R1) prefer for staff to ask my permission prior to manipulating my oxygen or my oxygen supplies. On August 27, 2024, at 12:47 p.m., LALD/RN-A stated R1's record did not include specific instructions for R1's oxygen use. On August 28, 2024, at 8:44 a.m., clinical nurse supervisor (CNS)-C stated she was not able to find any specific instruction in R1's record for ULPs other than to document [oxygen services] at 9:00 a.m., 4:00 p.m., and 9:00 p.m., on R1's MAR, other than, trach dome connected to humility and oxygen. CNS-C said that was possibly because R1 "self manages" oxygen. CNS-C confirmed oxygen was on R1's service plan. CNS-C stated the licensee would "clean up" R1's oxygen administration. On August 28, 2024, at 8:58 a.m., LALD/RN-A stated, to be honest, instructions are not in any of the resident records. The licensee's Medication & Treatment-Administration & Delegation policy dated August 1, 2021, noted when administration of medications or treatments/therapy is delegated or assigned to unlicensed personnel the licensee would ensure that the registered nurse had specified, in writing, specific instructions for each resident and documented those instructions in the resident's records.	01950		

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01950	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for one of two residents (R1) with health monitoring managed by the provider. 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:	01960		

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01960	Continued From page 21 R1's diagnoses include congested heart failure [CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs,] obesity, diabetes, shortness of breath and schizophrenia [chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior]. R1's service plan dated June 26, 2024, indicated R1 received medication administration, and oxygen. On August 26, 2024, at 12:04 p.m., the surveyor observed unlicensed personnel (ULP)-B prepare and administer torsemide [CHF/removal of excess fluid] 20 milligrams (mg) to R1 using proper technique. R1's medication administration record (MAR) dated August 1, 2024, through August 26, 2024, included: -torsemide 20 mg twice daily in a.m. (morning), and 1:00 p.m., Take an additional 20 mg daily as needed (PRN) for weight gain of, if overnight, five pounds in one week, swelling or worsening shortness of breath. R1's prescriber's order dated July 9, 2024, included the above medication. On August 27, 2024, at 11:04 a.m., R1's prescriber's order was reviewed with licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A stated R1 was not currently being monitored for weight gain. LALD/RN-A confirmed R1's weights were not being monitored and prescriber's order indicated weights should be monitored for medication administration.	01960		

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01960	Continued From page 22 The licensee's Medication & Treatment Orders policy dated August 1, 2021, noted the RN was responsible for assuring that: -current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the resident's records -communicated to the resident or responsible party -educate resident or responsible party on all medication and treatment orders -changes in orders were addressed in the resident's service plan and are communicated to the other staff. In addition, the licensed nurse would review all medication and treatment orders for progress and the licensed nurse would monitor and evaluate medication and treatment/therapy orders and services for effectives on a regular basis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=F	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 by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable	02310		

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02310	Continued From page 23 health care and medical, or nursing standards for one of one resident (R1) with hospital-style bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses include congested heart failure [CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs,] obesity, diabetes, shortness of breath and schizophrenia [chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior]. R1's service plan dated June 26, 2024, indicated R1 received medication administration, oxygen, stand by assist with transfers, shower assist, laundry and housekeeping services. On August 26, 2024, at 12:04 p.m., the surveyor observed unlicensed personnel (ULP)-B prepare medication for R1 using proper technique. ULP-B took a medication cup down to R1's room and administered the medication. R1 was lying in a hospital rail with both side rails in the raised position. R's Bed Rail Education and Consent form dated June 14, 2024, included: -potential benefits of bed rails, potential risks of bed rails	02310		

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02310	Continued From page 24 -medical symptoms requiring use of side rails, the client has generalized weakness and chronic respiratory failure -device in use: siderail -siderails are installed securely and maintained in good operating condition -frequency of use, when in bed, when transferring into bed, when getting out of bed -the siderail design is consistent with the FDA's (Food and Drug Administration) 2006 recommended dimensional measurements to reduce entrapment. This means siderail zones 1, 2, and 3 must not exceed 4.75". R1's record lacked a comprehensive assessment on the use of an assistive device to include measurements. On August 26, 2024, at 2:46 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated no one had ever told him bedrail measurements needed to be included in bedrail assessments. LALD/RN-A confirmed none of the bedrails used at the facility included measurements. The licensee's Side Rails policy dated August 1, 2021, noted when the licensee is aware a home care resident is utilizing side rails on a bed, the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and unitized consistent with the manufacture's directions. The Guidance for Industry and FDA (Federal and Drug Administration) Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006,	02310		

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02310	Continued From page 25 noted, reducing the risk of entrapment involves a multi-faceted approach that includes bed design, clinical assessment and monitoring, as well as meeting patient, resident, and family needs for vulnerable patients in most health care settings - hospitals, long term care facilities, and at home. Therefore, comprehensive bed safety programs in these settings will likely involve input from manufacturers as well as facility staff. Recognizing that not all hospital beds present a risk of entrapment, and that this risk may vary depending on the patient, FDA encourages manufacturers and facilities to work together to develop bed safety programs to evaluate and, if needed, mitigate entrapment risk. When evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care setting, not intended by the manufacturer. Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. FDA recommends that healthcare facilities conduct a risk-benefit analysis to ensure that steps taken to mitigate the risk of entrapment do not create different, unintended risks or reduce clinical benefits available to patients using legacy beds. Such steps may include checking with bed system manufacturers to identify compatible mattresses, rails, and accessories. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37378	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	3508 83RD AVENUE NORTH BROOKLYN CENTER, 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
02310	Continued From page 26 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". No further information provided. TIME PERIOD OF CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *08/27/24*
Time: 10:20:00
Report: 1013241098

Food and Beverage Establishment Inspection Report

Location:
Care Partners Homecare Llc
3508 83rd Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037993
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634582727
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.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

A HOT WATER SANITIZING RESIDENTIAL DISH MACHINE IS USED. THE FACILITY'S HIGH TEMP TEST KIT MEETING THE ABOVE REQUIREMENT WAS BROKEN. REPLACE THE TEST KIT.

Comply By: 09/10/24

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Eggs
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Meat
Temperature: 24 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Type: Full
Date: *08/27/24*
Time: 10:20:00
Report: 1013241098
Care Partners Homecare Llc

Food and Beverage Establishment Inspection Report

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator C. Casey.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, vinyl tile floor, painted walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, food storage, and food handling procedures.

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 1013241098 of 08/27/24.

Certified Food Protection Manager: Tabitha Vickie Briggs

Certification Number: 113885 Expires: 11/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Vickie Briggs
Operator

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us