DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 12, 2024

Licensee
Pure Heart Health Services, Inc.
6213 Lee Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 409121
Health Facility Identification Number (HFID) 39189
Project Number(s) SL39189015

Dear Licensee:

On January 17, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed September 9, 2023. The follow-up survey found the facility to be in compliance. Based on these findings, the condition on the license was removed effective January 17, 2024.

Effective January 17, 2024, MDH is granting your Assisted Living Facility facility license. You will not receive a replacement license certificate until your license is due to renew. If you have not received a letter from us with information regarding renewing your license within 45 days prior to your expiration date, please contact us at (651) 201-5273 or by email at: Health.assistedliving@state.mn.us.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39189	A. BUILDING: _____ B. WING _____	R 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HEART HEALTH SERVICES INC	6213 LEE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL39189015-1 On January 17, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on 09/27/2023. At the time of the survey, there were 0 residents receiving services under the provisional assisted living license. As a result of the revisit, the licensee is in compliance.	0 000		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for	{0 550}		

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{0 550}	Continued From page 1 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further actions required	{0 550}		
{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, 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	{0 650}		

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{0 650}	Continued From page 2 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further actions required	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further actions required	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	{0 680}		

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{0 680}	Continued From page 3 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further actions required	{0 680}		
{0 970} SS=F	144G.50 Subd. 5 Waivers of liability prohibited 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. This MN Requirement is not met as evidenced by:	{0 970}		

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{0 970}	Continued From page 4 No further actions required	{0 970}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family;	{01370}		

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{01370}	Continued From page 5 (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further actions required	{01370}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures	{01500}		

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{01500}	Continued From page 6 relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: No further actions required	{01500}		
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics	{01530}		

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{01530}	Continued From page 7 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; (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; This MN Requirement is not met as evidenced by: No further action required	{01530}		
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: No further action required	{02310}		

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Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

October 24, 2023

Licensee
Pure Heart Health Services Inc
6213 Lee Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 409121
Health Facility Identification Number (HFID) 39189
Project Number(s) SL39189015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 27, 2023, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b) is issuing a 90-day conditional provisional license due to expire on **January 22, 2024**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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 provisional 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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Pure Heart Health Services Inc a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Pure Heart Health Services Inc is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **Egress window requirements:** Pure Heart Health Services Inc will replace the proposed egress window in unoccupied resident room #1 with a window that will meet the minimum opening dimension of 648 square inches, and with opening height and width demensions of no less than 20 inches.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Pure Heart Health Services Inc is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Pure Heart Health Services Inc is in substantial compliance on the follow up survey, MDH will remove the conditions from Pure Heart Health Services Inc's assisted living facility provisional license, and Pure Heart Health Services Inc will correct violations identified during the survey to come into substantial compliance. If MDH determines Pure Heart Health Services Inc is not in substantial compliance, MDH may take additional enforcement action against Pure Heart Health Services Inc, including placement of additional conditions, issuing an extension to the conditional provisional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. The request for reconsideration should be addressed to:

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

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 Casey DeVries directly at: 651-201-5917.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39189015-0 On September 25, 2023, through September 27, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were zero (0) residents receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 surveyors' 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 subd. 1, 2, and 3.	
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 1 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required contact information for the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH). 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: On September 25, 2023, at 10:06 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A and administrator (A)-B stated they were familiar with the current minimum assisted living requirements.	0 550		

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0 550	Continued From page 2 On September 25, 2023, at 10:53 a.m., during the facility tour, the surveyor observed the licensee lacked the required OHFC posting and contact information. On September 25, 2023, at 12:00 p.m., CNS-A stated they did not know what the required OHFC posting was. Both CNS-A and A-B searched the facility postings but were unable to locate the required OHFC contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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, 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	0 650		

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	39189	A. BUILDING: _____ B. WING _____	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HEART HEALTH SERVICES INC	6213 LEE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 650	Continued From page 3 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 observation, interview, and record review, the licensee failed to ensure employee records contained required annual performance reviews for one of two employees (clinical nurse supervisor (CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: CNS-A was hired by the licensee on June 14, 2022, and provided oversite to unlicensed personnel and direct care to residents. CNS-A's employee record lacked an annual performance review due to be completed by June 14, 2023. On September 26, 2023, at 9:26 a.m., CNS-A stated they were missing their annual performance review. CNS-A stated they were aware of the annual performance review requirement but it was missed. The licensee's Performance Evaluations policy, undated, and referenced MN Statutes: 144A.479,	0 650		

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0 650	Continued From page 4 Subd. 7 (4) (A Home Care Statute), indicated, "A competency-based performance evaluation will be conducted for all employees after one (1) year of employment and at least annually thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct TB annual training for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 5 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: The Facility TB Risk Assessment was dated August 22, 2022, and identified the facility was at a low risk for TB transmission. It further indicated TB training was performed annually. CNS-A CNS-A was hired by the licensee on July 15, 2022, and provided oversite to unlicensed personnel and direct care to residents. CNS-A's employee record included an Educare (online training platform) Certificate of Completion for an OSHA and Infection Control training module completed on September 16, 2022. The training module included TB training. CNS-A's employee record lacked annual TB training which was due to be completed by September 16, 2023. ULP-C ULP-C was hired by the licensee on August 19, 2022, and provided direct cares to residents. ULP-C's employee record included an Educare Certificate of Completion for an OSHA and Infection Control training module completed on September 20, 2022. The training module included TB training.	0 660		

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0 660	Continued From page 6 ULP-C's employee record lacked annual TB training which was due to be completed by September 20, 2023. On September 26, 2023, at 10:16 a.m., CNS-A stated they were aware of the annual TB training requirements but had not completed annual TB for any of their employees. CNS-A stated it was their first year open and this was overlooked. CNS-A stated it was their responsibility to make sure required competency trainings were completed. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. It further indicated all health care personnel should receive TB education annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 7 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete an annual review of their emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors. 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: The licensee's EPP was observed to be out and available for residents, visitors, and staff to review on a kitchen shelf.	0 680		

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0 680	Continued From page 8 The licensee's Emergency Preparedness Plan last reviewed on September 1, 2022, lacked information to include the following: -annual review, an annual review was due on September 1, 2023; -supply needs for shelter in place; and -address role of facility under a waiver declared by the Secretary in accordance with section 1135. On September 26, 2023, at 1:45 p.m., clinical nurse supervisor (CNS)-A and administrator (A)-B both stated the annual review of their EPP was past due and was overlooked. The licensee's Emergency Preparedness policy dated September 1, 2022, indicated, "[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." It further indicated, "The emergency preparedness plan/program will be reviewed/updated at least annually." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (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,	0 790		

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0 790	Continued From page 9 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 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide current tags and documentation of annual and monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. 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). Findings include: On a facility tour on September 25, 2023, at approximately 10:52 a.m. to 11:52 a.m., with Administrator (A-B), it was observed that the fire extinguishers throughout the facility, did not have any current tags or documentation to indicate that annual and monthly inspections had been performed as required. Annual and monthly inspections of the fire extingushers are required by NFPA standards and Minnesota State Fire Code to ensure that all systems are maintained and remain in working order. A-B verbally confirmed survey staff observations.	0 790		

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0 790	Continued From page 10 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide proper door locking arrangements that did not constitute a distinct hazard to life. This had the potential to directly affect all residents and staff. It was also observed the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. 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	0 800		

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0 800	Continued From page 11 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). Findings include: On September 25, 2023, approximately between 10:52 a.m. to 11:52 a.m., survey staff toured the facility with the Administrator (A-B). During the facility tour, it was observed and verified the front and side emergency exit doors had dead bolts that required more than one operation to release and open. Exit door latch hardware is required to release, unlock, and open for the purpose of exiting in one operation. A-B stated the front and side doors will stay on the emergency exit plan and have one of the door locks removed. The following maintenance items was observed: It was observed that there was lint and dust build-up in the ceiling exhaust vent in the main floor bathroom. These deficient conditions were visually verified by A-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 12 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (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. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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. (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. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. The facility plan did not provide complete actions for employees to take in the event of a fire or similar emergency and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.	0 810		

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0 810	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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). Findings include: A record review and interview were conducted on September 27, 2023, between approximately 3:42 p.m. and 4:06 p.m. with Administrator (A-B), on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for relocation of	0 810		

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0 810	Continued From page 14 residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that drills were not being conducted every other month during the timeframe of 08/19/2022-09/13/2023 when residents were currently living here. During interview, A-B, verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced	0 820		

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0 820	Continued From page 15 by: Based on observation and interview, the licensee failed to provide properly sized egress windows for resident rooms that did not create a distinct hazard for residents. This had the potential to directly affect a portion of the residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 25, 2023, between the hours of 10:52 a.m. and 10:52 a.m., survey staff conducted a facility tour with Administrator (A-B). During facility tour, survey staff observed the following: A-B fully opened the proposed egress window in unoccupied resident room #1 and survey staff verified the measurement of the openable area of the window to be 31" high x 20" wide for a total of 620 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". A-B visually verified the deficient condition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 820		

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0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited 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. This MN Requirement is not met as evidenced by: 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 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 the potential to affect a large portion or all the residents). The findings include: R1's Assisted Living Contract signed on December 27, 2022, included the following waiver of liability: "4. LIABILITY Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment	0 970		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HEART HEALTH SERVICES INC	6213 LEE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 970	Continued From page 17 malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." On September 25, 2023, at 12:57 p.m., clinical nurse supervisor (CNS)-A stated they were unaware a waiver of liability could not be in their contract. CNS-A stated they used the same contract for both residents they've had and would need to update the contract they were using. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe	01370		

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01370	Continued From page 18 environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required competency training was completed for one of two unlicensed employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01370		

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01370	Continued From page 19 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on August 19, 2022, to provide direct care services to residents. ULP-C's employee record lacked the following documentation of required competency training to be completed by a registered nurse (RN): -medication, exercise and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; and -awareness of commonly used health technology equipment and assistive devices. On September 26, 2023, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated ULP-C was missing some of the required competencies which were missed during their initial training. CNS-A stated it was their responsibility to make sure required competency trainings were completed. The licensee's Qualifications, Training and Competency policy, undated, indicated: "5. Training and competency evaluations for all unlicensed personnel will include the following: a. Documentation requirements for all services provided - content of training, areas evaluated, and evidence of completion in personnel file b. Reports of changes in the resident's condition to the supervisor designated by the provider	01370		

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01370	Continued From page 20 c. Basic infection control, including blood-borne pathogens and pandemic policies d. Maintenance of a clean and safe environment e. Appropriate and safe techniques in personal hygiene and grooming, including: 1. Hair care and bathing ii. Care of teeth, gums, and oral prosthetic devices iii. Care and use of hearing aids; and iv. Dressing and assisting with toileting f. Training on the prevention of falls for providers working with the elderly or individuals at risk of falls g. Standby assistance techniques and how to perform them h. Medication, exercise, and treatment reminders i. Basic nutrition, meal preparation, food safety, and assistance with eating j. Preparation of modified diets as ordered by a licensed health professional k. Communication skills that include preserving the dignity of the resident and showing respect for the resident and resident's preferences, cultural background, and family l. Awareness of confidentiality and privacy m. Understanding appropriate boundaries between staff and residents and the resident's family n. Procedures to utilize in handling various emergency situations o. Awareness of commonly used health technology equipment and assistive devices" No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01500	Continued From page 21	01500		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 22 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-C). In addition, the licensee failed to include the required training topics for the annual training. 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:	01500		

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01500	Continued From page 23 CNS-A CNS-A was hired by the licensee on July 15, 2022, and provided oversite to unlicensed personnel and direct care to residents. CNS-A's employee record lacked annual training due to be completed in July 2023, to include the following topics: -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Infection control techniques; -Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -Review of provider's policies and procedures; and -Principles of person-centered planning/service delivery. ULP-C ULP-C was hired by the licensee on August 19, 2022, and provided direct cares to residents. ULP-C's employee record lacked annual training due to be completed in August 2023, to include the following topics: -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Infection control techniques; -Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -Review of provider's policies and procedures;	01500		

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01500	Continued From page 24 and -Principles of person-centered planning/service delivery. On September 26, 2023, at 10:10 a.m., CNS-A stated no annual trainings had been completed by any of their staff. CNS-A stated they oversaw making sure annual trainings were completed on time but were missed as they were new to the process. The licensee's Annual Training Requirements policy, undated, indicated, "All staff that provide direct care services in assisted living must complete at least eight (8) hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (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; (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	01530		

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01530	Continued From page 25 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training within 160 hours of providing direct care to residents for one of two direct care employees (unlicensed personnel (ULP)-C). In addition, the licensee failed to provide employees with the required two hours of annual dementia care training for two of two direct care employees (clinical nurse supervisor (CNS)-A and ULP-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) 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: CNS-A CNS-A was hired by the licensee on July 15, 2022, and provided oversite to unlicensed	01530		

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01530	Continued From page 26 personnel and direct care to residents. CNS-A's employee record lacked required annual training due to be completed in July 2023. ULP-C ULP-C was hired by the licensee on August 19, 2022, and provided direct cares to residents. ULP-C's employee record included Certificates of Completion totaling seven hours of dementia care training at the time of hire. The training was one hour short of the required eight hours of the initial dementia care training requirements. ULP-C's employee record lacked required annual dementia training due to be completed in August 2023. On September 26, 2023, at 10:10 a.m., CNS-A stated no annual trainings had been completed by any of their staff which included annual dementia care. CNS-A added up the total hours of initial dementia training completed by ULP-C and stated it was one hour short of the requirements. CNS-A stated they oversaw initial and annual trainings to be completed on time but were missed as they were new to the process. The licensee's Dementia Care Training policy, undated, indicated, "Direct care employees must have completed at least eight hours of initial training on required topics in the 160 hours from employment. Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements or a supervisor meeting the	01530		

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01530	Continued From page 27 requirements must be available for consultation with the new employee until the training requirement is complete." The policy addressed the required two hours of annual dementia care for supervisors and non-direct care staff but did not address the required two hours of annual dementia care training for direct care employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1) who utilized a consumer bed rail. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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).	02310		

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02310	Continued From page 28 The findings include: R1 was admitted to the licensee on August 10, 2023. R1's Service Plan dated August 9, 2023, indicated R1 received services for dressing, incontinence care, laundry, ambulation assistance, showering, and bed making. R1 was discharged from the licensee on September 13, 2023. R1's resident record included a Side-Rail Use Assessment form signed by clinical nurse supervisor (CNS)-A on December 23, 2022. The form was not signed by the resident or their guardian. The assessment identified zones 1-5 for required measurements according to the "Food and Drug Administration (FDA) recommended space," but was not completed. The form also lacked the following required components: - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - Risk vs. benefits discussion (individualized to each resident's risks); - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R1's resident record included an Admission Assessment dated December 23, 2022, which indicated, "Bed rail was in use to aid with bed mobility. Client and guardian are aware of use." The assessment also indicated, "The bed rail meets FDA guidelines," but lacked further	02310		

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02310	Continued From page 29 information. R1's resident record included an Admission Assessment dated September 5, 2023, which indicated, "Bed rail was in use to aid with bed mobility. Client and guardian are aware of use." The assessment also indicated, "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed," but lacked further information. On September 25, 2023, at 10:52 a.m., the surveyor observed R1's room which had a hospital bed with two hospital bed rails installed on it. CNS-A and the administrator (A)-B stated the hospital bed belonged to R1 and the bed rails were in use the entire time R1 lived in the home. On September 25, 2023, at 1:15 p.m., CNS-A stated they provided a risk versus benefits document form signed by the guardian, but it did not include measurements. CNS-A stated they had discussed R1's bed rail use with R1's case manager and it was determined it was a low risk for R1 to have the bed rails. CNS-A stated the durable medical equipment (DME) company were the ones who set up R1's hospital bed but CNS-A had not performed any measurements or assessments of the bed themselves. On September 26, 2023, at 9:08 a.m., CNS-A stated they looked at the manufacturer instructions when the hospital bed was delivered but were unsure if they still had a copy of them. CNS-A stated they were aware of some of the FDA requirements for assessing bed rail safety but did not know exact measurements of entrapment zones were required to be documented. CNS-A stated assessment were	02310		

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02310	Continued From page 30 completed during R1's regularly schedule assessments. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated 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 with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment;	02310		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 31 - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The MDH website also indicated, "licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information." The licensee's Use of Side Rails MN Statute 144D.07 policy, undated, indicated: "POLICY: Side rails will not be used in the assisted living setting except in situations where assessment determines they are necessary for safety of the resident. If the resident or resident's representative wants side rails on the bed, facility RN will educate the resident/representative about the risks related to side rails and will assess whether the side rails meet FDA standards. If the side rails do not meet safety guidelines, staff will recommend alternative options to reduce the fall risk. Prescriber orders will be obtained for the side rails if indicated. PURPOSE: -To establish parameters for the safe use of side	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39189	A. BUILDING: _____ B. WING _____	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HEART HEALTH SERVICES INC	6213 LEE AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 32 rails -To clarify facility policy on the need for and the safe use of side rails -To identify documentation requirements if side rails are used SPECIAL INSTRUCTIONS: 1. When notified that a resident has a side rail or that the resident or their representative is requesting side rails, the RN will assess and evaluate what the resident's needs are and if the resident can safely utilize the side rail/equipment. Assessment will determine whether the equipment meets the FDA standards for side rails. 2. If the RN determines that the resident is not able to safely use a side rail or that the side rail does not meet the FDA or most current safety guidelines, the RN will recommend that the side rail should be removed and will document this recommendation. The RN will document the teaching provided regarding the risks of using side rails. Documentation will include family members or resident's representative who received the education on the safe use of side rails. 3. If the RN determines that the side rails are not a safe device for the resident, the RN will provide options and alternatives for reducing falls. The RN will document these recommended options and the response from the resident, resident's family and/or resident's representative to the RN's recommendations. 4. A detailed document on side rails is found at http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm072729 .pdf. 5. Detailed information from FDA about Side Rail Safety, including information for both health care providers and for consumers and caregivers is found at	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39189	A. BUILDING: _____ B. WING _____	09/27/2023

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02310	Continued From page 33 http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/default.htm. The web page for consumers and caregivers can be printed as a handout for facility residents and their families." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *09/25/23*
Time: 15:51:08
Report: 8058231229

Food and Beverage Establishment Inspection Report

Location:
Pure Heart Health Services Inc
6213 Lee Avenue N
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0042080
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

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

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

ESTABLISHMENT REP: EMMANUEL BENSON
HRD INSPECTOR: JOEY KEEN

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

NO RESIDENTS AT THE TIME OF INSPECTION

Type: Full
Date: *09/25/23*
Time: 15:51:08
Report: 8058231229
Pure Heart Health Services Inc

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 8058231229 of 09/25/23.

Certified Food Protection Manager: EMMANUEL BENSON

Certification Number: 112920 Expires: 09/22/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

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