Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 11, 2024

Licensee
Midwest Homes Inc
158 71st Way Northeast
Fridley, MN 55432

RE: Project Number(s) SL36174015

Dear Licensee:

On September 11, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 13, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Electronically Delivered

July 18, 2024

Licensee
Midwest Homes Inc.
158 71st Way Ne
Fridley, MN 55432

RE: Project Number(s) SL36174015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 13, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36174	A. BUILDING: _____ B. WING _____	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	158 71ST WAY NE FRIDLEY, MN 55432

(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: SL36174015-0 On June 11, 2024, through June 13, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents; two (2) receiving services under the provider's Assisted Living license. On June 11, 2024, an immediate correction order was issued for tag identification 0470. The immediacy of order 0470 was removed on June 13, 2024. Noncompliance remained and the scope and level remain unchanged.	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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record (DOR) for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a 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 June 11, 2024, at 2:00 p.m., the surveyor reviewed the Board of Executives for Long-term Services and Supports (BELTSS) website with clinical nurse supervisor (CNS)-D who identified LALD-C as licensee's current LALD. The BELTSS website did not identify LALD-C as the DOR for licensee. LALD-C was identified as DOR for two (2) other locations with the same business name as licensee. On June 11, 2024, at 2:10 p.m., CNS-D stated LALC-C should have identified themselves as the DOR for licensee. CNS-D stated LALD-C would be notified they had failed to assign themselves	0 110		

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0 110	Continued From page 2 as the DOR for the licensee and licensee was aware LALD-C was required to identify themselves as the DOR. The licensee's 4.01 Assisted Living Director policy dated June 12, 2024, indicated licensee would have a LALD but the policy lacked indication the LALD would be identified as the DOR on the BELTSS website. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the	0 470		

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0 470	Continued From page 3 facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents for assistance with health and safety needs who were awake and located in the same building, in an attached building, or on a contiguous campus for two of two residents (R1, R2). 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: On June 11, 2024, at 10:00 a.m., surveyor arrived at the entrance of the licensee to initiate the entrance conference. The surveyor knocked on the door and rang the doorbell located at front door but received no answer. The surveyor could hear what sounded like talking coming from inside of the facility. Surveyor turned the front door handle and found it unlocked. Surveyor	0 470		

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0 470	Continued From page 4 opened door, announced self as a representative of the Minnesota Department of Health (MDH) and called out asking if anyone was home. No response was noted. The surveyor proceeded into the facility and followed sounds of talking and found TV in lower-level area on. A person, who was later identified as unlicensed personnel (ULP)-A, was noted to be laying on the couch with their head on a pillow and feet up on the couch. ULP-A's eyes were closed and ULP-A could be heard snoring. The surveyor did not awake the person to be respectful, as they were unidentified and could be a resident taking a nap. The surveyor proceeded to upper level and met R1 at the top of the stairs exiting their room. R1 proceeded to the lower-level and woke ULP-A asking about when R1's appointment was to occur. ULP-A noticed the surveyor and stated, "I'm sorry," and then asked R1 what they needed. R1 questioned ULP-A about their appointment and ULP-A stated they would leave at 10:45 a.m. ULP-A met with the surveyor after R1 returned upstairs and ULP-A stated, "Sorry about that. I have been feeling run down as I was on a plane back from Texas and have been tired." ULP-A stated they had to leave with R1 for R1's appointment. ULP-A stated R2 was able to stay home alone as they have alone time. ULP-A stated R2 is often left at home alone when staff take other residents out. On June 11, 2024, at 10:20 a.m., ULP-A received a phone call and answered it on speaker phone. The surveyor heard ULP-A stated to the person on the phone they needed to leave at 10:45 a.m. to take R1 to their appointment. The person on the phone stated, "You cannot leave until someone else gets there. You can't leave [R2] alone." ULP-A then took the phone call off of speaker phone and ULP-A stated, "Let me go	0 470		

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0 470	Continued From page 5 somewhere to talk." ULP-A left the area and completed the phone call outside of surveyor's ability to hear any further conversation from where surveyor was sitting and documenting. On June 11, 2024, at 11:45 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D stated licensee does not utilize sleeping staff as licensee was aware of the staffing requirements. The surveyor described observations described above to CNS-D. CNS-D stated ULP-A should not be sleeping, and licensee does not allow staff to sleep when they are to provide services to residents. CNS-D stated staff have been trained no resident is to be left alone in the home. CNS-D stated ULP-A was incorrect in their statement of leaving R2 alone when taking another resident out. CNS-D stated all staff have been trained to not leave residents alone. The licensee's 4.06 Staffing & Scheduling policy dated January 1, 2024, indicated licensee would develop and implement a staffing plan to meet the needs of the residents 24-hours a day, seven days a week, but lacked identification if staff would be awake or if a resident would be left alone. No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of order 0470 was removed on June 13, 2024. Noncompliance remained and the scope and level remain unchanged.	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 6 (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 June 12, 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		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 7 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A was hired September 16, 2022. ULP-A's undated My Transcript indicated ULP-A was trained on Infection Prevention and Control - PPE on December 13, 2022.	0 510		

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0 510	Continued From page 8 On June 12, 2024, at 8:35 a.m., the surveyor observed ULP-A provide medication administration to R1 and R2 in the common kitchen area. ULP-A washed their hands in the kitchen sink and donned (put on) gloves. ULP-A obtained R1's medication container from a locked kitchen cabinet and proceeded to administer R1's medications. ULP-A obtained milk from the refrigerator in the common kitchen and stated R1 preferred to take their medications with milk. ULP-A opened R1's medication bubble pack and dispensed R1's medications into their hand. Once R1 had swallowed their medications, ULP-A returned R1's medication container to the cabinet and obtained R2's medication container. ULP-A repeated the process for R2's medication administration. Once R2 had swallowed their medications, ULP-A returned R2's medication container, locked the kitchen cabinet with medications, doffed (removed) their gloves and washed their hands. On June 12, 2024, at 8:51 a.m., clinical nurse supervisor (CNS)-D stated ULP-A had not maintained proper infection control techniques while ULP-A used gloves. CNS-D stated ULPs are not trained to use gloves with medication administration and CNS-D was unsure why ULP-A had used gloves. CNS-D stated ULP-A should have changed gloves and performed hand hygiene between residents and donned new gloves once they had completed medication administration with R1. The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated employees would perform hand hygiene between tasks and procedures and with change of gloves. No further information provided.	0 510		

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0 510	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the 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). Findings include: On June 12, 2024, at 9:45 a.m., survey staff toured the facility with licensed assisted living	0 800		

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0 800	Continued From page 10 director clinical nurse supervisor (CNS)-D, and observed the following maintenance issues: 1. It was observed that cigarette butts and ashes were present between the garage and the front doorstep with no proper cigarette butt receptacle to put them in. 2. Bedroom #4 was missing the window cranks on the egress window. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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; (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	0 810		

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	36174	A. BUILDING: _____ B. WING _____	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	158 71ST WAY NE FRIDLEY, MN 55432

(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
0 810	Continued From page 11 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. This had the potential to affect all staff, residents, 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: On June 12, 2024, at 1:33 p.m., clinical nurse supervisor (CNS)-D provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the FSEP (fire safety evacuation	0 810		

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0 810	Continued From page 12 plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (rescue, alarm, confine, extinguish and evacuate) but the plan was designed for a building with life safety systems such as sprinklers, fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or fire-resistant construction. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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01290	Continued From page 13 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was associated with the licensee's current assisted living facility health facility identification (HFID) number in the Department of Human Services (DHS) NetStudy 2.0 website for one of two 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: ULP-B was hired on September 18, 2022. ULP-B's record lacked a BGS clearance letter associated with licensee's HFID. The licensee's DHS Netstudy 2.0 screenshot dated June 11, 2024, at 2:01 p.m., indicated all employees associated with licensee's HFID 36174 and lacked identification ULP-B was associated with licensee. ULP-B's screenshot on DHS Netstudy 2.0 dated June 11, 2024, at 2:02 p.m., indicated ULP-B was cleared to work and associated with another HFID 35007 owned by the same owner as the	01290		

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01290	Continued From page 14 licensee. On June 11, 2024, at 2:05 p.m., clinical nurse supervisor (CNS)-D stated the licensee was aware each employee was required to be associated with each HFID employees worked at. CNS-D stated the licensee missed ULP-B when NetStudy 2.0 was reviewed by licensee. CNS-D stated the licensee would log into NetStudy and associate all active employees with each appropriate HFID where each worked. The licensee's 4.03 Kari Koskinen Manager Background Check policy dated June 12, 2024, indicated the licensee would maintain a current BGS clearance letter for each employee who worked at the licensee's facility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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	01500		

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01500	Continued From page 15 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. 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	01500		

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01500	Continued From page 16 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 annual training was provided and included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-A, 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 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: ULP-A and ULP-B were hired September 16, 2022, and September 18, 2022, respectively. ULP-A and ULP-B's records both lacked evidence of annual training provided since either employee was hired. On June 12, 2023, at 11:03 a.m., clinical nurse supervisor (CNS)-D stated the licensee had not provided annual training as required to any employee. CNS-D stated employees were to complete assigned annual training, but the licensee was unable to locate where training was completed and topics that may have been covered. CNS-D stated the licensee would create new accounts for staff in the licensee's online	01500		

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01500	Continued From page 17 training program and have each employee complete the required training. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated the licensee would provide and document all required annual training in each employee's respected records. No further information 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 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	01530		

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01530	Continued From page 18 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 interview and record review, the licensee failed to ensure annual dementia care training was provided and included all required content for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-A, 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 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: ULP-A and ULP-B were hired September 16, 2022, and September 18, 2022, respectively. ULP-A and ULP-B's records both lacked evidence of annual dementia care training provided since either employee were hired. On June 12, 2023, at 11:03 a.m., clinical nurse supervisor (CNS)-D stated the licensee had not provided annual dementia care training as required to any employee. CNS-D stated employees were to complete assigned annual dementia care training, but the licensee was unable to locate where training was completed,	01530		

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01530	Continued From page 19 and content covered. CNS-D stated the licensee would create new accounts for staff in the licensee's online training program and have each employee complete the required dementia care training. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated the licensee would provide and document all required annual dementia training in each employee's respected records. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01760 SS=F	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 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 medication	01760		

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01760	Continued From page 20 administration was documented accurately for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 June 12, 2024, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-A administer R1's medications from the pharmacy-prepared medication bubble pack and document on R1's medication administration record (MAR). ULP-A stated medications were administered from the bubble packs as prepacked by licensee's contracted pharmacy and ULPs do not change the medications as packed. R1 was admitted on March 8, 2024. R1's E-Script New Prescription Request written March 7, 2024, read, "SEROquel [brand name for quetiapine, an antipsychotic medication] 200 MG [milligram] tablet - take one (1) tablet by mouth at bedtime." R1's MAR dated June 2024, included an order with a start date of March 8, 2024, that read, "Quetapine [sic] 200 MG tablet - take 1 tablet (200 mg) by mouth every night at bedtime," and was documented as administered on June 1, 2, 6, 7, 8, 9, 10, and 11, at 8:00 p.m.	01760		

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01760	Continued From page 21 R1's Week 4 medications dated May 14, 2024, was indicated by clinical nurse supervisor (CNS)-D as R1's current medications to be administered by ULPs packaged by licensee's contracted pharmacy. Each individual bubble pack included the date the medication would be administered. For each bedtime administration, the pack indicated the medications and dosages included in each administration. For each Bedtime administration the bubble pack read, "1 (one) - Quetiapine 300mg tab." On June 12, 2024, at 12:30 p.m., CNS-D contacted the licensee's contracted pharmacy to clarify the discrepancy between licensee's current record and pharmacy supplied medications. The pharmacy stated when the pharmacy contacted R1's provider to obtain a renewal order for R1's quetiapine order, R1's provider sent an increase in dosage to the pharmacy for quetiapine 300 mg, the current dosage R1 was taking. CNS-D stated the licensee was not aware of the increase in dosage and would need to update R1's record to reflect the current order. CNS-D stated ULPs were trained to check in medications when they arrive to ensure medications match each resident's record, but CNS-D was unsure why they were not contacted when the medication change occurred. The licensee's 7.16 Medication & Treatment Orders - Implementing policy dated January 1, 2023, indicated when a licensed nurse is not on duty when an order is received, the ULP would notify the licensed nurse within one hour of receipt. No further information provided.	01760		

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01760	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored per manufacture's direction for one of one resident (R1) with medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 12, 2024, at 10:40 a.m., an audit of R1's medication noted R1's current insulin aspart Flex-pen lacked an opened on or discard by date. R1 was admitted on March 8, 2024, with diagnosis which included bipolar I disorder, anxiety, psychosis, and Diabetes Mellitus type II.	01880		

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01880	Continued From page 23 R1's Medication Administration Report (MAR) dated June 2024, indicated R1 received insulin aspart pen per a sliding scale (dose determined by the resident's blood glucose check) three (3) times per day. On June 12, 2024, at 10:40 a.m., clinical nurse supervisor (CNS)-D stated all insulin pens must be dated when they are opened. CNS-D stated R1's long-acting glargine insulin pen was dated when it was opened, but the person who opened R1's aspart insulin must have forgot to date it. CNS-D took the undated insulin pen out of R1's medication container and stated the medication would be destroyed as licensee was unable to identify when the aspart pen was opened. CNS-D then opened a new insulin aspart pen, dated the pen, and placed it in R1's medication container for use. The National Library of Medicine's NOVOLOG drug instruction information revised April 2014, indicated unused insulin must be discarded 28 days after being open. The licensee's 7.11 Medication Storage policy dated January 1, 2023, indicated medications would be stored based on manufacturer's directions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *06/12/24*
Time: 10:00:00
Report: 1031241153

Food and Beverage Establishment Inspection Report

Location:

Midwset Homes Inc
158 71st Way Ne
Fridley, MN55432
Hennepin County, 27

Establishment Info:

ID #: 0038719
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7638983543
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

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

ESTABLISHMENT DID NOT HAVE ILLNESS LOG ON SITE. COPY OF LOG SENT WITH REPORT. PRINT AND KEEP ILLNESS LOG ON SITE AND UP TO DATE.

Comply By: 06/12/24

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

UTENSIL TEMPERATURE DISH MACHINE MEASURED < 150F. **DISCONTINUE USE OF DISH MACHINE FOR SANITIZING PURPOSES UNTIL REPAIRED.** CAN BE USED FOR WASH/RINSE. FILL SINK BASIN WITH SANITIZER WATER AND SANI DIP DISHES AFTER WASHING. ALLOW DISHES TO AIR DRY

Comply By: 06/12/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 06/14/24

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.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE OR WAX TEST STRIPS. PROVIDE IRREVERSIBLE MEASURING DEVICE OR WAX STRIPS AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 06/15/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KITS ON SITE. PURCHASE KITS AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)

Comply By: 06/14/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).

Comply By: 06/12/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

HOOD LIGHTS ARE BURNT OUT. REPLACE BOTH HOOD LIGHTS. CLEAN LIGHT ENCLOSURE PANELS WHEN TAKEN APART.

Comply By: 06/26/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

HANDLES ON CUPBOARDS AND CUPBOARD FRONTS HAVE BUILDUP OF DEBRIS. CLEAN FRONTS AND HANDLES.

Comply By: 06/26/24

Surface and Equipment Sanitizers

Dimethyl Ethyl Benzyl Ammo: = 400 at Degrees Fahrenheit
Location: 3M Kitchen Cleaner
Violation Issued: No

Chlorine: = 200 at Degrees Fahrenheit
Location: Bleach Spary Bottle
Violation Issued: No

Hot Water: < at 150 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

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

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

All violations discussed with PIC during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Staff must prepare chlorine sanitizer squirt bottle. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

Type: Full
Date: *06/12/24*
Time: 10:00:00
Report: 1031241153
Step Forward 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 Environmental Health inspection report number 1031241153 of 06/12/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Gemini Spears
Person in Charg

Signed:_____
Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031241153

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	3
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 06/12/24
Time In 10:00:00
Time Out

Step Forward Inc	Address	City/State	Zip Code	Telephone
	158 71st Way Ne	Fridley, MN	55432	7638983543

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038719		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
Supervision				
1	IN (OUT)	PIC knowledgeable; duties & oversight		
2	IN (OUT) N/A	Certified food protection manager, duties		
Employee Health				
3	IN (OUT)	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices				
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands				
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
Approved Source				
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination				
15	(IN) OUT N/A N/O	Food separated and protected		
16	IN (OUT) N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
Time/Temperature Control for Safety				
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT (N/A) N/O	Proper reheating procedures for hot holding		
20	IN OUT (N/A) N/O	Proper cooling time & temperature		
21	IN OUT N/A (N/O)	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A (N/O)	Time as a public health control: procedures & records		
Consumer Advisory				
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations				
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances				
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures				
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 06/12/24

Inspector (Signature)