Electronically Delivered

July 19, 2022

Administrator
H & H Group Home, LLC
3541 Aquilla Avenue South
Saint Louis Park, MN 55426

RE: Project Number(s) SL37884015

Dear Administrator:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial evaluation on May 18, 2022, for the purpose of assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should addressed to:
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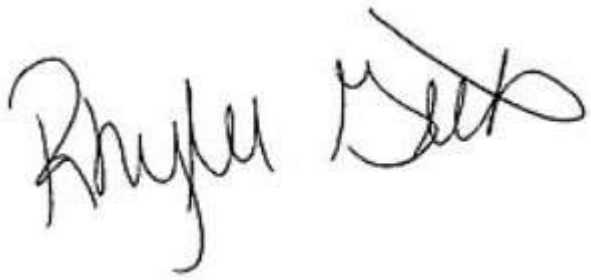
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 218-232-8285 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37884	A. BUILDING: _____ B. WING _____	05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
H & H GROUP HOME LLC	3541 AQUILLA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#37884015 On May 16, 2022 through May 18, 2022 the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey there was 1 residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United	0 480		

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0 480	Continued From page 1 States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect one resident of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated May 16, 2022 . TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 700	Continued From page 2	0 700		
0 700 SS=C	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident records were protected against unauthorized disclosure when one of one resident, R1, medical records were stored on top of a cabinet in a public area. 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: On May 16, 2022, at approximately 1:00p.m., resident records were observed stored in a room without doors which was located between the kitchen and living room common areas. The records were stacked on top of a filing cabinet. The records contained R1's medical records including history, provider notes, physician orders, and assessments.	0 700		

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0 700	Continued From page 3 On May 17, 2022, at approximately 3:00 p.m. R1's medical records from two separate medical appointments dated October 26, 2021, and another appointment dated February 2, 2022, were folded in half and placed on a table in the same open room as R1's records were stored. During an interview on May 18, 2022, at approximately 4:45 p.m., assisted living director in residence (ALDIR)-A stated R1's personal records should be filed and put into R1's record and the entire record should be kept in the locked filing cabinet. The licensee's policy titled Resident Record-Access & Storage dated March 15, 2022, indicated resident records would be kept confidential and locked in a secured area. In addition, staff were responsible to maintain confidentiality of all resident records. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 700		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding;	0 770		

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0 770	Continued From page 4 (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a space for outdoor activities for residents. This had the potential to directly 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 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 residents). The findings include: On May 17, 2022, between 10:45 a.m. and 11:30 a.m., survey staff toured the facility with the Assisted Living Director in Residence (ALDIR)-A. During the facility tour, survey staff observed the outdoor space that would be used by residents was unsuitable for use by residents at the time of the survey. The yard was uneven and overgrown at the time of the survey and was being used for the storage of miscellaneous items. There was no seating area provided. The driveway in front of the outdoor space had areas that were heaved, broken or missing, and generally uneven enough to be considered a tripping hazard.	0 770		

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0 770	Continued From page 5 ALDIR-A verbally confirmed survey staff observations during the facility tour. ALDIR-A stated they were working on getting the outdoor area in better shape and were behind schedule due to recent storms in the area. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 770		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside and in the immediate vicinity of sleeping rooms and failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly 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 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 residents). The findings include: On May 17, 2022, between 10:45 a.m. and 11:30 a.m., survey staff toured the facility with the Assisted Living Director in Residence (ALDIR)-A. During the facility tour, survey staff observed the smoke alarm outside bedroom #4 in the basement was located around the corner and under a bulkhead. When the unlicensed professional (ULP)-D tested the smoke alarms, they were not interconnected. ALDIR-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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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's 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 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) 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 residents). The findings include: On May 17, 2022, from approximately 10:45 a.m. to 11:30 a.m., survey staff toured the facility with the Assisted Living Director in Residence (ALDIR)-A. During the facility tour, survey staff observed the following: 1. The closet in basement bedroom #3 had a large gap in the drywall by the structural beam. The drywall in the closet was not finished or	0 800		

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0 800	Continued From page 8 painted. 2. The basement bathroom wall by the shower was not finished to the ceiling. Fiberglass batt insulation was exposed along the shower and over the bathroom door. The insulation would be exposed to water vapor if the shower was used which could lead to the potential growth of mold inside the wall and insulation. The wall was also not sealed around a pipe penetration. 3. The laundry room and mechanical room are accessed through basement bedroom #4 by way of what was a closet at one point. Public spaces and utility spaces cannot be accessed through private bedrooms. 4. The basement floor had gapping between the ends of the floorboards in the area around the stairs. The floor should be installed correctly and provide a continuous surface that is not a tripping hazard. 5. The upstairs bathroom fan was covered in lint and dust. The shower was also covered in what appeared to be soap scum or a gray film that had built up over time. ALDIR-A verbally confirmed survey staff observations during the facility tour. No further information was 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	0 810		

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0 810	Continued From page 9 (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 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 interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 10 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 the potential to affect a large portion or all residents). The findings include: During interview on May 17, 2022, at 11:45 a.m., the Assisted Living Director in Residence (ALDIR)-A stated they had just opened and the only employees were her and the unlicensed professional (ULP)-D. ALDIR-A stated she had done the training for ULP-D but had not done any drills yet because they had only been open for a month at the time of the survey. Review of the fire safety and evacuation plans showed no evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation. The policy was written by a third party and ALDIR-A had not updated it yet to be accurate to her facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01440	Continued From page 11	01440		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees, assisted living director in residence (ALDIR)-A (who was also providing care) and unlicensed personnel (ULP)-D, with employee records reviewed. This practice resulted in a level two violation (a	01440		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
H & H GROUP HOME LLC	3541 AQUILLA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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
01440	Continued From page 12	01440		

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:

Assisted living director in residency (ALDIR)-A (training and not currently licensed), who also works as unlicensed personal, was hired August 1, 2021

During observations on May 16, 2022, at approximately 2:00p.m. ALDIR-A was observed administering medication to R1

Review of ALDIR-A employee file lacked documentation of RN supervision within 30 days of providing delegated nursing tasks.

ULP-D's hire date to provide assisted living services was March 4, 2021.

During observation on May 17, 2022, at approximately 9:00 a.m. ULP-D was observed administering medication to R1.

Review of ULP-D employee file lacked documentation of RN supervision within 30 days of providing delegated nursing tasks.

During interview on May 17, 2022, at approximately 10:55 a.m. ALDIR-A and RN-C indicated they had no knowledge of the requirement for a RN to provide a supervisory visit of ULP performing a delegated task within the first 30 days of employment. RN-C stated

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01440	Continued From page 13 there was no supervisory form in the packet of documentation required for each resident. The licensee's policy titled Supervision of Staff-Delegated Services dated March 15, 2022, indicated direct supervision of staff performing delegated tasks must be provided within 30 of beginning employment and thereafter as needed based on performance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all services were provided and implemented as directed in the current service plan for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the facility on April 3, 2022, with diagnoses including, depression, chronic pain syndrome, hypertension, and hypothyroidism. R1's Individualized Medication Management plan dated April 3, 2022, indicated R1 required medication administration and management by staff. Medication was set up by a facility nurse and staff would contact the RN at anytime with any questions or concerns regarding medication administration. In addition, the plan indicated documentation of all medications, verification of medications administered as prescribed, and monitoring medication for side effects would all be noted on R1's Medication Administration record (MAR) R1's Assisted Living Service Plan dated April 5, 2022, indicated R1 received assistance with	01640		

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01640	Continued From page 15 medication administration, grooming, toileting, bathing, and dressing. R1's Physician Orders dated April 6, 2022, indicated R1 had medication orders for oral and topical medications. Although the facility indicated they were managing R1's medications, R1's medical record contained no medication administration record for April 2022. R1's nursing note dated April 30, 2022, indicated R1's MAR for May 2022, was created and a new pharmacy would begin providing R1's medications May 1, 2022. During interview on May 16, 2022, at 10:30 a.m. ALDIR-A stated R1's service plan indicates the facility would provide medication management and administration to R1. ALDIR-A stated the facility had no documentation of medication administration provided in April 2022. During interview on May 16, 2022, at 3:30 p.m., RN-C stated although R1's service plan directed staff to provide medication administration to the resident, the facility had no documentation of medications administered by the facility for R1 during the month of April 2022. The licensee policy titled Service Plan, dated April 15, 2022, indicated the licensee would implement and provide all services indicated in the service plan. In addition, staff providing services shall be informed of the current service plan. TIME PERIOD TO CORRECT: Seven (7) days.	01640		

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01730	Continued From page 16	01730		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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01730	Continued From page 17	01730		

changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to develop and implement an individualized medication management plan for one of one resident reviewed (R1).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

R1 was admitted to the facility on April 3, 2022, with diagnoses including, depression, chronic pain syndrome, hypertension, and hypothyroidism.

R1's Individualized Medication Management plan dated April 3, 2022, indicated R1 required medication administration by staff. Medication was set up by the facility nurse and staff would contact the RN at anytime with questions or concerns regarding medication administration. In addition, the plan indicated documentation of all medications, verification of medications administered as prescribed, and monitoring medication for side effects would all be noted on

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01730	Continued From page 18 R1's Medication Administration record (MAR) R1's Assisted Living Service Plan dated April 5, 2022, indicated R1 received assistance with services including medication administration, grooming, toileting, bathing, and dressing. R1's Physician Orders dated April 6, 2022, indicated R1 was prescribed oral and topical medications. During interview on May 16, 2022, at approximately 10:30 a.m., unlicensed personal (ULP)-D and assisted living director in residency (ALDIR)-A stated R1 did not have documentation of medication administration for April 2022. During the month of April 2022, R1 did not take medication during the day related to religious beliefs. R1's medication management plan did not include R1's religious beliefs nor was there any plan developed to direct staff on a plan when the resident was not taking her medication as prescribed. During interview on May 16, 2022, at 3:30 p.m., ALDIR-A and RN-C stated R1 was observing religious holiday and did not take medication consistently during the month. They acknowledge R1's medication management plan did not direct staff on an individualized plan for R1 medication plan during the month of April 2022. RN-C stated she did not notify the provider that R1 was not taking medication as prescribed.. RN-C stated there was no direction or plan for staff to observe for any complications, risks, or side effects related to R1 not taking prescribed medications consistently. RN-C stated the licensee was expected to manage R1's medication. During interview on May 17, 2022, at 2:30 p.m.	01730		

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01730	Continued From page 19 R1 stated for religious reasons she did not take medication during the daytime. The licensee's policy titled Medication management Individualized Plan dated March 15, 2022 indicated the licensee would develop and maintain a current and individualized medication plan for each resident and updated with changes. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/16/22*
Time: 13:30:00
Report: 1025221091

Food and Beverage Establishment Inspection Report

Location:
H & H Group Home Llc
3541 Aquilla Avenue South
St Louis Park, MN55426
Hennepin County, 27

Establishment Info:
ID #: 0039243
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526887713
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-301.12A ** Priority 2 **

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

Kitchen has a 2 compartment sink; until a 3 compartment sink for the establishment is provided, use alternative receptacles to complete Wash/Rinse/Sanitize cycle of dishes, utensils, etc (C).

Comply By: 05/16/22

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.

Provide a test kit appropriate for the sanitizer being used for food contact surfaces (e.g. chlorine for using household unscented bleach).

Comply By: 05/18/22

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

Discussed staff health and hygiene, illness reporting, recording, and exclusion. Provided half card sheet on employee illness, information on MDA recall notices. Food sources reported as Cub, Sam's Club, local butcher/grocery for specific menu items. Discussed food preparation temperatures for raw animal foods, frozen foods, storage order for raw and ready-to-eat foods. Temperature measuring device (min/max thin probe) available for use. Discussed food contact surfaces (e.g. prep surfaces which can be easily W/R/Sanitized), durable utensils, and wash/rinse/sanitize with the two compartment sink and dishwasher. Two compartment sink designated with a handwashing sink (left) and a food sink (right) – provide a basin (bus tub, etc) for sanitizing dishes washed and rinsed in the dishwasher (e.g. chlorine solution at 50-100 PPM or another approved sanitizer), or use the food compartment sink. Submerge items for ~ 1 minute

and let air dry, or as label instructions indicate (rack space available). Discussed TCS foods, definition and treatment of food, date marking of prepared or open commercially prepared items, and foods which must be used or discarded within seven days. Reported no animal foods served raw or undercooked; discussed highly susceptible populations and food preparation requirements.

Food portions not heated and cooled; discussed equipment and finish requirements should cooling of hot TCS foods occur. Discussed chemical use and storage, testing sanitizing solutions, resident personal items, placement of any future chest freezers (avoid placing under unshielded lights and waste lines), pest control, when to discard food, notification of emergencies (e.g. foodborne illness, reportable illness among staff/residents).

Staff attended a CFPM course and reported their course certificate will be turned in with application and fee for CFPM certificate. Discussed the requirement and the purpose of the CFPM. Post/keep a copy of the certificate when obtained in the establishment. For another application copy or more information, please see do a general internet search for "MDH CFPM."

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 1025221091 of 05/16/22.

Certified Food Protection Manager: TBD

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Naijma

Signed: 

Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025221091

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

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

Date 05/16/22
Time In 13:30:00
Time Out

H & H Group Home Llc	Address: 3541 Aquilla Avenue South	City/State: St Louis Park, MN	Zip Code: 55426	Telephone: 9526887713
License/Permit #: 0039243	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

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				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		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		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:** 05/17/22

Inspector (Signature) Cory Kline