DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 20, 2024

Licensee
Global Case Management - East St. Paul
217 Winifred Street East
Saint Paul, MN 55107

RE: Project Number(s) SL34919015

Dear Licensee:

On May 15, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 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,

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

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Electronically Delivered

April 15, 2024

Licensee
Global Case Management-East St Paul
217 Winifred Street East
Saint Paul, MN 55107

RE: Project Number(s) SL34919015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34919	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL CASE MGMT-EAST ST PAUL	217 WINIFRED STREET EAST SAINT PAUL, MN 55107

(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: SL34919015-0 On March 11, 2024, through March 13, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living license. 2310: An immediate order was identified on March 12, 2024, at a level 2/Widespread (F). The immediacy was lifted on March 14, 2024, after survey exit and remains at a scope/level of F.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 March 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		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	0 680		

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0 680	Continued From page 2 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan dated August 1, 2023, lacked evidence of the	0 680		

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0 680	Continued From page 3 following required content: - establishment of the emergency program that describes the facility's approach to meeting health/safety/security needs of staff/residents and how facility would coordinate with other health care facilities, as well as community on a whole during emergency or disaster; - arrangements/contracts to re-establish utility services; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - policies and procedures based on the EP, risk assessment and communication plan; - Policy and procedure to address food, water, medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - Policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff and sheltered residents; - policy and procedure to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility; - policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address the use of volunteers, including the process/role for	0 680		

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0 680	Continued From page 4 integration; - policy and procedure that address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address role of facility under a waiver declared by the Secretary; - communication plan that included all the following names/contact information: staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - communication plan that included information for Federal, State, tribal, regional and local EP staff; state licensing and certification agency; - communication plan that included primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies; - communication plan that included a method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii); - communication plan that included a means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction; - communication plan that included a method for sharing information EP with residents and their families/representatives; - emergency plan training and testing program; - policy and procedure for initial training in emergency program to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected roles; and - emergency prep testing requirements. - Missing Resident Policy dated August 1, 2021, failed to be reviewed twice a year as	0 680		

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0 680	Continued From page 5 required. On March 13, 2023, at 1:30 p.m., licensed assisted living director (LALD)-A stated all information for emergency preparedness was in the licensee's emergency preparedness binder and he was unaware the emergency preparedness plan did not have all the required content. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 780		

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0 780	Continued From page 6 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install smoke alarms that complied with fire protection requirements. 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 of the residents). The findings include: On March 11, 2024, at 3:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: 1. A smoke alarm was not installed outside resident bedrooms one, two, and three. 2. A smoke alarm was not installed outside resident bedrooms four and five. Smoke alarms were not installed outside each sleeping area in the immediate vicinity of bedrooms. During the facility tour interview, on March 11, 2024, LALD-A verified smoke alarms were not provided outside the bedrooms. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 3:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the last monthly inspection recorded on	0 790		

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0 790	Continued From page 8 the fire extinguisher tags was December 21, 2023. No inspections were recorded for 2024. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, on March 11, 2024, LALD-A verified fire extinguisher inspection records were missing for January and February 2024. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to 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	0 800		

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0 800	Continued From page 9 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 3:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: 1. In occupied resident bedroom five, the casement egress window would not open far enough to provide the required clear opening. When the egress window was opened by LALD-A, it was blocked by the window well cover. When the window well cover was removed, the egress window opened fully and was no longer obstructed. All paths of egress must provide unobstructed exiting. Window well covers must not interfere with the opening of the window in any way. During an interview on March 12, 2024, at 4:00 p.m., LALD-A verified the egress window obstruction and stated a new window well cover had already been ordered. 2. There were holes in the wall by the front door. During an interview on March 12, 2024, at 4:00 p.m., LALD-A verified the holes in the wall required repair. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 10 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 record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 11 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 potential to affect a large portion or all of the residents). The findings include: On March 12, 2024, the licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included a fire safety policy dated August 1, 2021. This policy was a template and had not been developed for use at this facility. The FSEP fire safety policy 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 employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP fire safety policy did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. The FSEP fire safety policy directs employees to	0 810		

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0 810	Continued From page 12 evacuate residents from the building but fails to include information on where residents should relocate to in the event of a fire. The FSEP failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including the unique needs of residents evident by a lack of these procedures in the plan. One resident was identified as a priority code level 2 defined as dependent on medical equipment or whose mobility prevents them from exiting the building without assistance. Evacuation procedures for residents identified with a priority code level 2 were not included in the FSEP. During an interview with survey staff on March 12, 2024, at 4:00 p.m., LALD-A verified the FSEP was a template and required more detail. LALD-A stated residents would relocate to the backyard recycling area in the event of an evacuation and verified this was not included in the FSEP. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by fire drill reports lacking the required frequency. One fire drill was recorded during January 2024 and one fire drill was recorded in February 2023. Three utility disruption drills and one civil unrest drill were recorded in 2023. The utility and civil unrest drills did not simulate the evacuation of the facility. During an interview on March 12, 2024, at 4:00 p.m., LALD-A verified the evacuation drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 13 (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include required verbatim	0 950		

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0 950	Continued From page 14 language giving residents the right to identify a designated representative on it's own separate page for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the assisted living licensee on August 1, 2021. R1's service plan dated December 1, 2023, indicated R1 received services for meal preparation, assistance with activities of daily living (ADLs), mental health management and medication management. R1's Resident Contract for Assisted Living signed July 1, 2023, page one included an option to select or decline naming a designated representative. Page two, subsection 1, Parties To Agreement, which lacked customization with the licensee's name, indicated, "This Resident Agreement (the "Agreement") is a contract between the Resident(s) named on the first page of the Agreement and [Legal Name of AL Licensee]. Throughout this Agreement, the terms "we" and "our" refer to [Name of Licensee} and the terms "you", "your" and "Resident" refer to the Resident(s) and the Designated Representative if one is named. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you,	0 950		

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0 950	Continued From page 15 receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney health care agent"), if applicable. If Resident has a legally appointed guardian or conservator or any other legally appointed representative ("Legal Representative"), Resident shall provide Management with a copy of any legal papers designating such a relationship prior to execution of this Agreement, and the guardian, conservator or other legally appointed representative shall execute this Agreement on behalf of the Resident." On March 13, 2024, at 1:30 p.m. licensed assisted living director (LALD)-A stated R1's contract, which was the same contract used for all residents, lacked required designated representative verbatim language and were not on their own page separate from the contract and was mixed in with additional contract statements and information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060		

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01060	Continued From page 16 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	01060		

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01060	Continued From page 17 licensee failed to provide a written notice with required content, to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R4). 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: R4 began receiving services on July 14, 2022. R4's Observation note dated April 2, 2023, identified "[R4] had called 911 claiming that he would kill himself." Emergency personnel arrived and transported R4 to the hospital. The staff then notified licensed assisted living director (LALD)-A and the registered nurse. R4's discharge summary dated April 6, 2024, identified R4 had been hospitalized for mental health reasons. R4 was refusing to return to the facility and wanted placement closer to his family. R4 was therefore discharged on April 6, 2024. R4's record lacked evidence of a written notice that contained: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060		

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01060	Continued From page 18 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R4's record lacked evidence the resident, legal representative, and designated representative, or the ombudsman had been provided a written notice including the above noted information. On March 12, 2024, at 9:35 a.m. LALD-A stated he did not have emergency relocation information for R4, and he was unaware of the requirement. LALD-A stated while R4 was hospitalized, he informed the hospital staff he did not want to return to the home and wanted to be placed somewhere closer to his family, therefore R4 was discharged on April 6, 2023. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services	01370		

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01370	Continued From page 19 provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one	01370		

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01370	Continued From page 20 unlicensed personnel (ULP-C) completed training and competency evaluations in all required training topics. 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-C was hired to provide direct care services for the licensee on September 1, 2023. On March 12, 2024, at 7:46 a.m. ULP-C was observed administering medications to R1, R2, and R3. ULP-C's employee record lacked evidence training and/or competency testing was completed on the following required topics: - standby assistance techniques and how to perform them; and - understanding appropriate boundaries between staff and residents and the resident's family. On March 13, 2024, at 1:30 p.m. licensed assisted living director (LALD)-A stated he was unaware ULP-C's training was missing some of the required training topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01440 SS=D	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 supervision of unlicensed staff as required for one of two unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01440		

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01440	Continued From page 22 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired to provide direct care services for the licensee on September 1, 2023. On March 12, 2024, at 7:46 a.m. ULP-C was observed administering medications to R1, R2, and R3. ULP-C's employee record lacked evidence a 30-day supervision had been completed. On March 13, 2024, at 12:10 p.m. clinical nurse supervisor (CNS)-B stated she typically did a 30-day supervision; however, it was not in ULP-C's file so it must have been missed. The licensee's Supervision-Comprehensive Services policy dated May 26, 2020, indicated direct supervision of unlicensed staff performing delegated tasks would be completed within 30 days after the individual begins providing delegated tasks. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days	01620		

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01620	Continued From page 23 after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a comprehensive assessment every 90 days 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).	01620		

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01620	Continued From page 24 The findings include: On March 12, 2024, at 7:46 a.m. unlicensed personnel (ULP)-C was observed administering medications to R1. R1 was admitted to the assisted living licensee on August 1, 2021. R1's service plan dated December 1, 2023, indicated R1 received services for meal preparation, assistance with activities of daily living (ADLs), mental health management and medication management. R1's 90 Day Home Care Reassessments dated February 15, 2024, was an abbreviated form of the licensee's Comprehensive Physical Assessment last completed for R1 on December 1, 2023. R1's Home Care Reassessment did not include all of the elements on the uniform assessment tool as required. On March 12, 2024, at 11:30 a.m. clinical nurse supervisor (CNS)-B stated she annually completed the Comprehensive Physical Assessment and completed the 90 Day Home Care Reassessments every 90 days for all residents. CNS-B stated she was unaware a comprehensive assessment need to completed every 90 days and was unaware of the required elements of the uniform assessment tool. On March 13, 2024, at 12:10 p.m. CNS-B stated she was unaware of the Minnesota Rules 4659.0150 Uniform Assessment Tool and the contents required in the assessment. In addition, CNS-B stated she was unaware of the rules that specify the contents of uniform assessment.	01620		

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01620	Continued From page 25 The licensee's undated, Nursing Assessment and Reassessment of Clients policy identified "The RN will re-assess each client on an on-going basis and will revise the client ' s service plan based on the client ' s needs. The RN will determine the frequency of re-assessments based on the client ' s needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or	01700		

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01700	Continued From page 26 designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content 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 March 12, 2024, at 7:46 a.m. unlicensed personnel (ULP)-C was observed administering medications to R1. R1 was admitted to the assisted living licensee on August 1, 2021. R1's diagnoses included brain injury and Parkinson's disease. R1's service plan dated December 1, 2023, indicated R1 received services for meal preparation, assistance with activities of daily	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34919	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01700	Continued From page 27 living (ADLs), mental health management and medication management. R1's Medication Assessment/Delegation form dated February 15, 2023, identified a list of medications, dose and frequency. The form contained a column titled reason prescribed and side effects; however, the section was blank for all medications. The assessment failed to include for all medications the indications for use, side effects, and contraindications. On March 13, 2024, at 12:10 p.m. clinical nurse supervisor (CNS)-B stated she was unaware she needed to include indications for use, side effects, and contraindications in her medication assessment. The licensee's Assessment for Medication Management Program policy dated May 29, 2020, "1. The clinician will provide and document a face-to-face assessment with the client. 2. The assessment includes the following elements. a. Identification of all medications, including over the counter and herbal/dietary supplements b. Medication reconciliation i. Identification of the most accurate list of all medications the client is taking, including the name, dosage, frequency, and route by comparing the client record to an external list of medications obtained from the client, hospital, prescriber of other providers ii. Assessment of the following: 1. Indication for medications 2. Effectiveness of drug therapy 3. Side effects 4. Immediate desired effects 5. Unusual and unexpected effects	01700		

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01700	Continued From page 28 6. Actual or potential drug interactions 7. Duplicate drug therapy 8. Non-adherence with drug therapy 9. Drug therapy currently associated with laboratory monitoring. 10. Allergic reactions 11. Changes in condition that contraindicate continued administration of the medication." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with side rails. This resulted in an immediate order on March 12, 2024. 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	02310		

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02310	Continued From page 29 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 1:30 p.m., surveyor observed R1 to be laying in a hospital bed with bilateral upper half bed rails. R1 began receiving services under the licensee's Comprehensive Home Care license on January 18, 2021, and began receiving services under the licensee's Assisted Living license on August 1, 2021. R1's diagnoses included brain injury and Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves with symptoms including tremor, slowed movements, rigid muscle, and impaired balance). R1's physicians orders dated November 18, 2023, included three antidepressants, two seizure medications, medication to treat Parkinson's Disease, and a medication to treat dementia. R1's Side-Rail Use Assessment Form dated July 31, 2021, identified R1 had bilateral siderails. The assessment indicated R1 had alteration in safety awareness due to cognitive decline, had a history of falls, displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed, received medications that required safety precautions, and had requested side rails for safety and/or comfort. The assessment also indicated interventions included lowering the bed to the floor, provide frequent staff monitoring at night, and provide assisted toileting at night. The assessment identified R1 had been informed of	02310		

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02310	Continued From page 30 the risks and benefits of the siderails. R1's Comprehensive Physical Assessment dated December 1, 2023, identified R1 had tremors, left sided weakness, diminished judgement, R1 was forgetful, agitated, and had impulsive behaviors. The assessment indicated R1 had a history of a serious brain hemorrhage at a young age, and currently had Parkinson's disease and mood disorders. The assessment indicated R1 had a hospital bed but failed to identify R1 had side rails. R1's Falls Risk Assessment dated December 1, 2023, identified R1 was ambulatory and incontinent. The assessment indicated R1 took multiple medications and had diagnoses that would increase risk for falls. The assessment identified a total risk score greater than 10 represented a high risk for falls, and R1's total score was an 11. R1's record lacked evidence a side rail assessment had been completed since July 31, 2021. The licensee's undated "House Binder" identified the following: -Resident Information Sheet which identified medical equipment: hospital bed -Service Plan task identified R1 was at risk of falling - staff were to assist as needed and to watch closely at night. Staff were to assist with toileting and showering as needed. The House Binder failed to identify R1 had side rails. On March 12, 2024, at 11:30 a.m., registered nurse (RN)-B stated she had not completed a side rail assessment for R1 and was unaware of	02310		

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02310	Continued From page 31 the requirements. On March 12, 2024, at 1:22 p.m., licensed assisted living director (LALD)-A stated when R1 first received the hospital bed with the siderails an assessment was completed including measurements. He was unaware the assessment needed to be completed every 90 days. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's Side Rail Use policy dated May 26, 2020, identified the following: -"RN is responsible to ensure that the side rails in use are of a safe design and properly maintained." -"The need for side rails will be reassessed and documented as needed, but not less than every 90 days." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated February 20, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to	02310		

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02310	Continued From page 32 the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On March 14, 2024, the immediacy was removed based on supervisory review. The scope and level remain at a level 2/Widespread (F).	02310		

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

Type: Full
Date: *03/12/24*
Time: 12:50:00
Report: 1039241068

Food and Beverage Establishment Inspection Report

Location:
Global Case Mgmt-East St Paul
217 Winifred Street East
St Paul, MN55107
Ramsey County, 62

Establishment Info:
ID #: 0039345
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7639996914
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.

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

BLEACH SPRAY BOTTLE MEASURED >200 PPM CHLORINE. BLEACH SOLUTION WAS DILUTED TO 100 PPM TO COMPLY WITH ABOVE. CORRECTED ON SITE. INSTRUCTED PERSON-IN-CHARGE TO PREPARE FUTURE SOLUTIONS TO APPROPRIATE DILUTION.

Corrected on Site

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: COLD HOLD REFRIGERATOR
Violation Issued: No

Process/Item: CHICKEN NUGGETS
Temperature: Degrees Fahrenheit - Location: FROZEN IN FREEZER
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Stacy Haag.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, tile floor, painted walls and ceiling and faux-marble countertops.

The kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. A separate handwashing sink is present as well.

A residential dishwashing machine is present in the kitchen. Per color-change thermo test strip, the dish washing machine achieves a utensil surface temperature of 160 degrees F.

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing.

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 1039241068 of 03/12/24.

Certified Food Protection Manager: Yasin Abshir

Certification Number: FM94527 Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Yasin Abshir
person-in-charge

Signed: _____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us