Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 13, 2025

Licensee
Esteem Home Health Services
4024 Idaho Avenue
Crystal, MN 55427

RE: License Number 417903
Health Facility Identification Number (HFID) 37006
Project Number(s) SL37006015

Dear Licensee:

On January 21, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed July 11, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective February 13, 2025.

State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Please Note: This notice amends the Notice of Conditional License dated October 31, 2024. Specifically, a typo in the total openable area required for an egress window has been corrected to 648 (previously, the typo reflected 248) square inches (4.5 square feet). No other changes have been made.

Electronically Delivered

November 1, 2024

Licensee
Esteem Home Health Services
4024 Idaho Avenue
Crystal, MN 55427

RE: Conditional License Number 409131
Health Facility Identification Number (HFID) 37006
Project Number(s) SL37006015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on October 2, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **January 29, 2025**.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 11, 2024, found not corrected at the time of the October 2, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - $3,000.00
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - $500.00
0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on October 2, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

IMPOSITION OF FINES:

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.

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

listed above.

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

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

a. **Health Facility Construction Permit:** Esteem Home Health Services will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect Sate Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. Within 14 days from the date of this notice, Esteem Home Health Services will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. **General Contractor:** Esteem Home Health Services must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email **within two (2) weeks of the date of this notice:**

    i. Name

    ii. License Number

    iii. Contact Information

c. **Egress Window Requirements:** Esteem Home Health Services will replace at least one window in occupied resident bedrooms #1, meeting the minimum size requirements.

    i. Must have minimum openable width of no less than 20 inches.
    ii. Must have minimum openable height of no less than 20 inches.
    iii. Must have total openable area of no less than 648 square inches (4.5 square feet).
    iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
    v. All measurements much be achieved under normal operation of opening window without the use of a key, too. or special knowledge.

d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Esteem Home Health Services is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Esteem Home Health Services is in substantial compliance on the follow up survey, MDH will remove the conditions from Esteem Home Health Services' assisted living facility license, and Esteem Home

Health Services will correct any outstanding violations identified during the survey. If Esteem Home Health Services is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 31, 2024

Licensee
Esteem Home Health Services
4024 Idaho Avenue
Crystal, MN 55427

RE: Conditional License Number 409131
Health Facility Identification Number (HFID) 37006
Project Number(s) SL37006015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on October 2, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **January 29, 2025**.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 11, 2024, found not corrected at the time of the October 2, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - $3,000.00
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - $500.00
0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on October 2, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

IMPOSITION OF FINES:

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.

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 and immediately correct any reissued orders 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.

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REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
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CONDITIONAL LICENSE ISSUED:
MDH will issue Esteem Home Health Services a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Esteem Home Health Services is in substantial compliance.

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

a. **Health Facility Construction Permit:** Esteem Home Health Services will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect Sate Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. Within 14 days from the date of this notice, Esteem Home Health Services will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. **General Contractor:** Esteem Home Health Services must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email **within two (2) weeks of the date of this notice:**

   i. Name

   ii. License Number

   iii. Contact Information

c. **Egress Window Requirements:** Esteem Home Health Services will replace at least one window in occupied resident bedrooms #1, meeting the minimum size requirements.

   i. Must have minimum openable width of no less than 20 inches.
   ii. Must have minimum openable height of no less than 20 inches.
   iii. Must have total openable area of no less than 248 square inches (4.5 square feet).
   iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
   v. All measurements much be achieved under normal operation of opening window without the use of a key, too. or special knowledge.

d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Esteem Home Health Services is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Esteem Home Health Services is in substantial compliance on the follow up survey, MDH will remove the conditions from Esteem Home Health Services' assisted living facility license, and Esteem Home Health Services will correct any outstanding violations identified during the survey. If Esteem Home Health Services is not in substantial compliance on the follow-up survey, MDH may take additional enforcement

action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	R 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL37006015-1 On September 30, 2024, through October 2, 2024, the Minnesota Department of Health conducted a follow up survey with the above provider to follow-up on orders issued pursuant to a survey completed on July 11, 2024. At the time of the survey, there were 3 active residents; all of whom were receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
{0 470} SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	{0 470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	R 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
{0 470}	Continued From page 1 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the facility had sufficient staffing 24/7 to meet the scheduled and reasonably foreseeable unscheduled needs, as required by the resident's assessments and service plans, for one of one resident (R1) who required a mechanical lift. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was	{0 470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	R 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 470}	Continued From page 2 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). INITIAL SURVEY: R1 had diagnoses to include type 2 diabetes mellitus. R1's most recent nursing assessment, dated August 19, 2024, indicated R1 required two staff to assist with all transfers. On September 30, 2024, R1 was observed leaving the facility in her motorized wheelchair. On October 1, 2024, at 11:00 a.m., the surveyor reviewed the licensee's daily schedule for the weeks of September 8, 2024, to September 21, 2024, titled, "[facility name] Weekly Work Schedule 2024". The schedules indicated the licensee had one staff member scheduled from: -3:00 p.m. to 11:00 p.m. on September 9, 11,13-18, 20-21, 2024; -3:00 p.m. to 8:00 p.m. on September 10 and 19, 2024; and -11:00 p.m. to 7:00 a.m., September 8-21, 2024. On September 30, 2024, at 12:00 p.m., housing manager/unlicensed personnel (HM/ULP)-B stated she created the schedule and there was only one staff member scheduled on the overnight shift. HM/ULP-B stated the night shift started at 8:00 p.m., to assist getting R1 into bed. HM/ULP-B further stated she was not aware there needed to be two staff working the overnight shift. On October 1, 2024, at 3:00 p.m., chief executive	{0 470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	R 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
{0 470}	Continued From page 3 officer/licensed assisted living director (CEO/LALD)-A stated their budget did not allow for two staff to be scheduled at night and they had been working with R1's case worker to try to obtain additional funding. CEO/LALD-A stated they had scheduled a "floater" to be on-call to come in at night if needed. CEO/LALD-A further stated the licensee would start scheduling two staff to meet the state requirement. The licensee's undated, staffing management and contingency staffing plan indicated "the agency assigns two staff to every resident needing one-on-one attention, needing transfers, and making sure that two staff are on AM (7 AM - 3 PM) & PM (3 PM - 11 PM), & OVERNIGHT (11 PM -7 AM) shifts seven days a week." The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated June 1, 2023, noted the number of unlicensed direct care staff typically scheduled was one, and transfers with assist of two staff was available. Minnesota Administrative Rule 4659.0180, Subpart 5 dated August 11, 2021, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." No further information was provided.	{0 470}		
{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}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	R 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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{0 480}	Continued From page 4 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 September 10, 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	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	R 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
{0 680}	Continued From page 5 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (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: Not reviewed during this survey.	{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	{0 780}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	R 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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{0 780}	Continued From page 6 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; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 780}		
{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: Not reviewed during this survey.	{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 7 (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: Not reviewed during this survey.	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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{0 820}	Continued From page 8	{0 820}		
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	{0 820}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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{0 820}	Continued From page 9 On September 30, 2024, at 11:45 a.m., survey staff observed the occupied resident bedroom #1 with housing manager/unlicensed personnel (HM/ULP)-B. HM/ULP-B stated the licensee had not yet installed the new window and they were working on getting it replaced. HM/ULP-B provided survey staff with the licensee's fire watch log. The log indicated a fire watch every 30 minutes from the initial issue of the immediate order on July 10, 2024, to the current date of the follow up survey. On September 30, 2024, at 2:32 p.m., chief executive officer/licensed assisted living director (CEO/LALD)-A provided correction order documentation, dated September 30, 2024. The documentation indicated the licensee secured a contractor on July 15, 2024, who, as of September 15, 2024, was unable to get a window, thus had not replaced the window in bedroom #1. The documentation further indicated the licensee contacted a second contractor on September 15, 2024, who would measure the window on October 2, 2024. On October 2, 2024, at 2:30 p.m., CEO/LALD-A stated there had been a bracket that had been blocking the window from being able to fully open. CEO/LALD-A stated he had a contractor measure the window without the bracket and the measurements were 20 inches in height and 26.5 inches in width. CEO/LALD-A stated he felt the window in bedroom #1 was now in compliance. The survey staff explained the windows did not meet the minimum requirements for total openable area. A document from "Best Price Siding" dated October 2, 2024, indicated, "Windows open up to 26.5 inches wide, 20 " [inches] tall". The	{0 820}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 820}	Continued From page 10 document did not indicate any agreement of work to be completed. On October 3, 2024, at 1:15 p.m., the survey staff observed the window in bedroom #1 with CEO/LALD-A. The clear openable area of the opened windows measured 20 inches in height and 27 inches in width, with a total openable area of 540 square inches. The survey staff explained the windows did not meet the minimum requirements for total openable area, and the correction order would be reissued. CEO/LALD-A acknowledged the above findings, and stated the licensee would replace the window to be compliant with the regulation, but it would be financially difficult. CEO/LALD-A further stated he felt the wording of the regulation was confusing. No further information was provided.	{0 820}		
{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	{01440}		

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{01440}	Continued From page 11 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: Not reviewed during this survey.	{01440}		
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	{01470}		

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{01470}	Continued From page 12 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01470}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	{01500}		

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{01500}	Continued From page 13 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	{01500}		

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{01500}	Continued From page 14 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01500}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01880}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	{01890}		

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{01890}	Continued From page 15 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01890}		

Electronically Delivered

August 6, 2024

Licensee
Esteem Home Health Services
4024 Idaho Avenue
Crystal, MN 55427

RE: Project Number(s) SL37006015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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, the following fines are assessed pursuant to this survey:

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L Anderson

Renee L Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: SL37006015-0 On July 8, 2024, through July 11, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 8, 2024, issued for SL37006015-0, tag identification 0470. On July 9, 2024, the immediacy of order 0470 was removed, however, non-compliance remained at a scope and level of G. Two immediate correction orders were identified on July 10, 2024, issued for SL37006015-0, tag identification 0820 and 1290. On July 11, 2024, the immediacy of correction orders 0820 and 1290 were removed, however	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	

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	37006	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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0 000	Continued From page 1 non-compliance remained at a scope and level of G and I, respectively.	0 000		
0 470 SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the facility had sufficient staffing to meet the scheduled and	0 470		

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0 470	Continued From page 2 reasonably foreseeable unscheduled needs, as required by the resident's assessments and service plans 24/7, for one of one resident (R1) who required a mechanical lift. This resulted in an immediate correction order on July 8, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). R1 had diagnoses to include type 2 diabetes mellitus. R1's most recent nursing assessment dated May 3, 2024, indicated R1 required two staff to assist with all transfers. On July 8, 2024, at 10:45 a.m., the surveyor observed housing manager/unlicensed personnel (HM/ULP)-B and unlicensed personnel (ULP)-D assist R1 into an electric wheelchair using a mechanical lift (a device used to transfer residents, if they cannot bear weight). On July 8, 2024, at 11:00 a.m., the surveyor reviewed the licensee's daily schedule for the months of June and July titled, [facility name] Weekly Work Schedule 2024. The schedules indicated the licensee had one staff member scheduled from: -7:00 a.m. to 9:00 a.m. on June 2-29, 2024; -2:00 p.m. to 4:00 p.m. on June 10-15, 24-29, 2024; -2:00 p.m. to 7:00 p.m. on June 3-8, 17-20, 22, 23, 2024; -2:00 p.m. to 11:00 p.m. on June 2, 9, 16, 21 and	0 470		

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0 470	Continued From page 3 30, 2024; -11:00 p.m. to 7:00 a.m., on June 2-30, and July 1-6, 2024. On July 8, 2024, at 1:00 p.m., HM/ULP-B stated she created the schedule and there were times when only one staff member had been scheduled, "when [R1] is just up sitting in the chair, but we always use two people to transfer her." HM/ULP-B further stated she was the back-up to the ULP and would come in and assist with a transfer if needed or if there was an emergency. The licensee's undated, staffing management and contingency staffing plan indicated "the agency assigns two staff to every resident needing one-on-one attention, needing transfers, and making sure that two staff are on AM (7 AM - 3 PM) & PM (3 PM - 11 PM), & OVERNIGHT (11 PM -7 AM) shifts seven days a week." The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated June 1, 2023, noted the number of unlicensed direct care staff typically scheduled was one, and transfers with assist of two staff was available. The mechanical lift user manual dated 2022, indicated "although [manufacturer] recommends that two assistants be used for all lifting preparation and transferring-from and transferring-to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the healthcare professional for each individual case." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470		

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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: (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 July 9, 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	0 680		

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0 680	Continued From page 5 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (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 have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 6 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Emergency Preparedness Manual, last reviewed February 29, 2024, lacked the following required content: -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; -develop policy and procedures to address: -provision of subsistence needs for staff and residents to include food and water -use of volunteers, including the process/role for integration; -role of the licensee under a waiver declared by the secretary in accordance with section 1135; -EP testing requirements including an annual full-scale exercise or individual facility-based functional exercise. On July 11, 2024, at 11:37 a.m., chief executive officer/licensed assisted living director (CEO/LALD)-A, stated he was not aware of the annual full-scale exercise or individual facility-based functional exercise requirement, and thought the licensee's plan contained all the required content. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance, dated August 1, 2021, indicated the emergency preparedness plan would include all required element of appendix Z and be reviewed annually. No further information was provided.	0 680		

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0 680	Continued From page 7 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 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 provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all	0 780		

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0 780	Continued From page 8 staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 10, 2024, at 10:00 a.m., survey staff toured the facility with the chief executive officer/licensed assisted living director (CEO/LALD)-A. During the facility tour, it was observed the sleeping rooms that were equipped with smoke alarms were not interconnected upon testing so actuation of one alarm would cause all alarms to operate. During the interview on July 10, 2024, at 11:00 a.m., CEO/LALD-A stated the smoke alarms in the facility were not interconnected, and the actuation of one alarm would not cause all alarms to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 800		

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0 800	Continued From page 9 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: The licensee failed to maintain 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 and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 July 10, 2024, at 10:00 a.m., survey staff toured the facility with the chief executive officer/licensed assisted living director (CEO/LALD)-A. During the facility tour, survey staff observed the following items: In resident room #5 on the lower level, it was observed that the ceiling plaster was bubbled, and the ceiling had brown stains with evidence of water damage. In resident room #3, it was observed that the door was damaged and had a hole. In resident room #2 on the main level, the main door was blocked by furniture, and there was no	0 800		

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0 800	Continued From page 10 clear path to egress. The carpet was ripped at the stair nosings in the exit stair from the lower level to the main level, creating tripping hazards. On the side of the building, it was observed leftover construction materials and house equipment were stored. It was also observed the piles of removed portions of the wood deck and deck posts were stored next to the existing wood deck. On the wood, the nails and screws were exposed and were a hazard to residents. Outside the exit door to the backyard, burnt cigarettes were disposed of in a plastic paint bucket without a proper disposal container, creating a possible fire hazard. Used cigarettes were also disposed of on wood rails and on wood landings in the garage. During the facility tour on July 10, 2024, at 11:00 a.m., CEO/LALD-A confirmed the facility was not in good repair in regard to resident health and safety in accordance with the maintenance and repair program and verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 11 (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 develop a fire safety and evacuation plan with the required elements 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	0 810		

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0 810	Continued From page 12 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 July 10, 2024, at 12:00 p.m., the chief executive officer/licensed assisted living director (CEO/LALD)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. The FSEP included the following discrepancies: - The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or doors that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. - The FSEP indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station.	0 810		

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0 810	Continued From page 13 The FSEP 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 FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm, clear the exit corridor, and close fire doors in case of fire, but the facility did not have a fire alarm system, fire doors. During the interview on July 10, 2024, at 12:30 p.m., CEO/LALD-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to	0 820		

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ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
0 820	Continued From page 14 correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the resident in occupied bedroom #1 on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 10, 2024, at 10:00 a.m., survey staff toured the facility with the chief executive officer/licensed assisted living director (CEO/LALD)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom #1 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 18 inches in height and 27 inches in width, with a total openable area of 486 square inches. The windows did not meet the minimum requirements for opening height and did	0 820	This immediate correction order identified on July 10, 2024, has had the immediacy lifted as of July 11, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 15 not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to CEO/LALD-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. CEO/LALD-A verbally confirmed the findings. On July 10, 2024, at 11:00 a.m., during the interview, survey staff explained to CEO/LALD-A that an immediate correction order was issued for the above finding. CEO/LALD-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith	01290		

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01290	Continued From page 16 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and cleared in affiliation with the assisted living licensee, prior to providing services, for one of five employees, house manager/unlicensed personnel (HM/ULP-B). This resulted in an immediate correction order on July 10, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: HM/ULP-B was hired on May 13, 2021, to perform managerial duties and to provide direct cares and services to residents. The licensee's staffing schedule for June 30, 2024, through July 13, 2024, indicated HM/ULP-B was scheduled to work the following: -7:00 a.m. to 3:00 p.m. on July 8, 9, 10, 11, 12, and 13; and -11:00 p.m. to 7 a.m., on July 6, 7, 8, 9, 10, and 13.	01290		

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01290	Continued From page 17 On July 8 through July 10, 2024, during the survey, HM/ULP-B was observed to provide assistance to residents and perform managerial duties. HM/ULP-B's employee record included a letter from the Department of Human Services (DHS) which indicated the employee was clear to work under program number 35241 (the licensee's comprehensive home care health facility identification (HFID), which was closed December 2022). The licensee lacked documentation of a cleared BGS for HM/ULP-B, affiliated to the licensee's current HFID (37006). On July 10, 2024, at 12:09 p.m., the DHS NETstudy 2.0 database indicated HM/ULP-B was not included on the licensee's employee BGS roster. On July 10, 2024, at 11:00 a.m., chief executive officer/licensed assisted living director (CEO/LALD)-A provided the surveyor with a Final Registry Form dated August 19, 2022. The form included registry review information from an initiated background study under the licensee's closed comprehensive home care HFID. The document indicated "this applicant has not been previously eligible for employment and must be fingerprinted." -CEO/LALD-A stated he thought the form indicated HM/ULP-B had been cleared. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 18 (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 (housing manager/unlicensed personnel (HM/ULP)-B, ULP-D). 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 19 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: HM/ULP-B and ULP-D were hired May 13, 2021, and March 28, 2022, respectively, to provide direct cares and services to residents. On July 8 through July 10, 2024, during the survey, HM/ULP-B and ULP-D were observed to provide assistance to the licensee's residents. HM/ULP-B and ULP-D's record lacked evidence the RN conducted direct supervision within 30 days of performing delegated tasks. On July 11, 2024, at 2:41 p.m., RN-C stated she did the competency testing with employees on hire, but was unaware a 30-day supervision need to be completed and had not been doing them. The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated August 1, 2021, indicated supervision of staff performing delegated tasks would be provided within 30 calendar days of when the individual began working and first performed delegated tasks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation	01470		

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01470	Continued From page 20 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01470		

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01470	Continued From page 21 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired March 28, 2022, to provide direct cares and services to residents. On July 9, 2024, at 10:15 a.m., the surveyor observed ULP-D administer medications to R1.	01470		

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01470	Continued From page 22 ULP-D's employee record lacked documentation the following orientation topics were completed: -Review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person; and -Review of the types of assisted living services the employee will provide, and the provider's scope of license. On July 11, 2024, at 11:37 a.m., chief executive officer/licensed assisted living director (CEO/LALD)-A, stated he thought he had provided the surveyor all the orientation and training for the ULP, but he could check in another binder. CEO/LALD-A further stated he would send the surveyor everything he could find. The licensee's 4.05 Employee Records policy, dated August 1, 2021, indicated the employee record would contain documentation of all training and in-service education required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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01500	Continued From page 23 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01500		

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01500	Continued From page 24 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (housing manager/unlicensed personnel (HM/ULP)-B, ULP-D). 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 of the residents). The findings include: HM/ULP-B and ULP-D were hired May 13, 2021, and March 28, 2022, respectively, to provide direct cares and services to residents. On July 8, 2024, at 10:45 a.m., the surveyor observed HM/ULP-B and ULP-D assist R1 into an electric wheelchair using a mechanical lift (a device used to transfer residents, if they cannot bear weight). HM/ULP-B and ULP-D's employee records both	01500		

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01500	Continued From page 25 lacked evidence either employee had successfully completed at least eight hours for every 12 months of employment as required under 144G.63, Subd.5, to include the following: - review of provider's policies and procedures. On July 11, 2024, at 11:37 a.m., chief executive officer/licensed assisted living director (CEO/LALD)-A, stated he thought he had provided the surveyor all the orientation and training for the ULP, but he could check in another binder. CEO/LALD-A further stated he would send the surveyor everything he could find. The licensee's 4.05 Employee Records policy, dated August 1, 2021, indicated the employee record would contain documentation of all training and in-service education required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and according to the manufacturer's directions for one of one resident	01880		

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01880	Continued From page 26 (R1) with refrigerated medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's service plan, signed July 16, 2023, indicated R1 received services including assistance with medication management, grooming, bathing, meals, laundry, and housekeeping. R1's nursing assessment, dated May 3, 2024, indicated R1 was not able to administer her own medications. R1's medication administration record for July 2024, indicated R1 received assistance with medication administration including: -novolog (insulin aspart, a rapid-acting insulin), at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m., daily; and -lantus (insulin glargine, a long-acting insulin), at 9:30 p.m., daily. On July 10, 2024, at 9:45 a.m., the surveyor and unlicensed personnel (ULP)-D observed R1's personal refrigerator located in R1's room. The refrigerator was unlocked and contained various food items. Shelves on the inside door of the refrigerator contained clear plastic baggies with injectable medications: 12 injection pens of lantus and 4 injection pens of novolog. The refrigerator	01880		

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01880	Continued From page 27 lacked a thermometer to record temperature. On July 10, 2024, at 9:55 a.m., ULP-D stated the insulin was kept in R1's room because she liked to keep the medications close to her. ULP-D further stated the refrigerator was kept unlocked. On July 10, 2024, at 4:23 p.m., registered nurse (RN)-C stated she was not aware the medications were being kept in R1's room and the medications should have been stored in the locked refrigerated outside of R1's room. The manufacturer's prescribing information for the use of novolog, insulin aspart injection, dated March 2023, indicated the medication should be refrigerated at 36-46 degrees when not in use. The manufacturer's prescribing information for the use of lantus, insulin glargine injection, revised June 2023, indicated the medication should be refrigerated at 36-46 degrees when not in use. The licensee's 7.11 Medication Storage Policy, dated August 1, 2021, indicated medications would be stored consistent with each resident' medication management plan, kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
01890	Continued From page 28 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On July 11, 2024, at 9:45 a.m., the surveyor observed the medication cabinet and observed the following time sensitive medications were opened without an opened date label: - novolog (insulin aspart, a rapid-acting insulin), and - lantus (insulin glargine, a long-acting insulin). On July 11, 2024, at 9:45 a.m., housing manger/unlicensed personnel (HM/ULP)-A verified there was not a label on the medication and stated there should be a label with the date, time, and initials of whoever opened it. On July 11, 2024, at 2:41 p.m., registered nurse	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
01890	Continued From page 29 (RN)-C stated staff were trained to date time sensitive medication, including insulin, and she was not sure why the medications were not dated. The manufacturer's prescribing information for the use of novolog, insulin aspart injection, dated March 2023, indicated the medication should be discarded 28 days after first use. The manufacturer's prescribing information for the use of lantus, insulin glargine injection, revised June 2023, indicated the medication should be discarded 28 days after first use. The licensee's 7.11 Medication Storage Policy, dated August 1, 2021, indicated medications would be stored consistent with the manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *07/09/24*
Time: 09:55:00
Report: 1043241173

Food and Beverage Establishment Inspection Report

Location:
Esteem Home Health Services
4024 Idaho Avenue
Crystal, MN55427
Hennepin County, 27

Establishment Info:
ID #: 0039149
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 8482301286
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS FOODS (MILK, PORK, BUTTER, ETC) IN COOLER MEASURED ABOVE 41F, SEE DATA CHART. PER STAFF, FOOD WAS PURCHASED PRIOR TO INSPECTION. STAFF WAS ADVISED TO STORE & HOLD TCS FOODS AT 41F OR BELOW IN A DIFFERENT COOLER/FREEZER. COMPLY WITH ABOVE RULE.

Comply By: 07/09/24

4-300 Equipment Numbers and Capacities

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

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

NO THERMOMETER PROVIDED. ADVISED STAFF TO PROVIDE AND MAINTAIN WITHIN THE FACILITY. COMPLY WITH ABOVE RULE.

Comply By: 07/09/24

5-200C Plumbing: Maintenance, fixture location

5-204.11 ***** Priority 2 *****

MN Rule 4626.1095 Locate a handwashing sink to allow convenient use in food preparation, food dispensing, warewashing areas and in or adjacent to toilet rooms.

KITCHEN HAS A TWO COMP SINK. ADVISED STAFF TO DESIGNATE ONE BASIN AS THE HANDWASHING SINK AND PROVIDE A LABEL. COMPLY WITH ABOVE RULE.

Comply By: 07/09/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

BOILED EGGS STORED IN COOLER. PER STAFF, EGGS WERE BOILED THE PREVIOUS NIGHT. ADVISED STAFF TO DISCONTINUE PRACTICE AND DISCARD LEFTOVER FOODS AT THE END OF THE DAY FOR SAME DAY SERVICE. COMPLY WITH ABOVE RULE.

Comply By: 07/09/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

SEE COMMENT.

Comply By: 07/09/24

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: AMBIENT
Temperature: 49 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 46 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: PORK
Temperature: 50 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: BUTTER
Temperature: 48 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: CHICKEN
Temperature: 35 Degrees Fahrenheit - Location: THAWING
Violation Issued: No

Process/Item: CHICKEN WINGS
Temperature: 41 Degrees Fahrenheit - Location: THAWING
Violation Issued: No

Type: Full
Date: *07/09/24*
Time: 09:55:00
Report: 1043241173
Esteem Home Health Services

Food and Beverage Establishment Inspection Report

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

Inspection was completed with Tammy Carlson as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, illness policy ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

4-501.11AB
4-500 Equipment Maintenance and Operation
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
1. AMBIENT AND TCS FOODS IN COOLER MEASURED ABOVE 41F. MAINTENANCE WAS SCHEDULED FOR 7/23 DURING INSPECTION. STAFF WAS ADVISED TO PROVIDE A TEMPORARY COOLER/FREEZER TO STORE TCS FOODS AT 41F OR BELOW UNTIL MAIN COOLER IS REPAIRED/REPLACED.
2. ICE BUILD UP AROUND TOP PERIMETER OF CHEST FREEZER CAUSING THE LID TO NOT CLOSE PROPERLY. ADVISED STAFF TO DEFROST FREEZER OR REMOVE THE TOP LAYER OF ICE.
COMPLY WITH ABOVE RULE.

**Foods cooked by the facility staff should be fully cooked and prepared for same day service only with leftovers discarded.

**This facility has a residential kitchen with residential equipment. Contact Health Regulation Division for plan review when facility undergoes remodeling.

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 1043241173 of 07/09/24.

Certified Food Protection Manager: Emmanual Whegar

Certification Number: FM108016 Expires: 08/28/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Grace Kemokai
PIC

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us