Electronically Delivered

October 18, 2024

Licensee
Premium Home Healthcare LLC
9020 Prestwick Pkwy North
Brooklyn Center, MN 55443

RE: Project Number(s) SL37678015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 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.

MDH concludes the licensee is in substantial compliance. 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.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

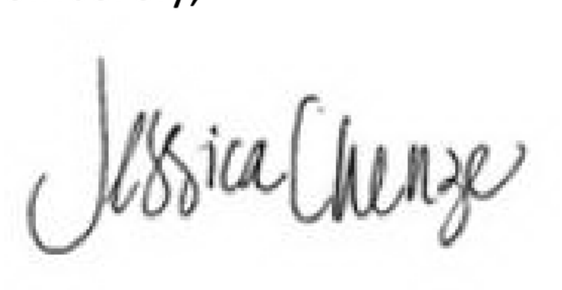
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37678	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIUM HOME HEALTHCARE LLC	9020 PRESTWICK PKWY NORTH BROOKLYN CENTER, MN 55443

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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: SL37678015 On September 16, 2024, through September 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; two receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 17, 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		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United	0 485		

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0 485	Continued From page 2 States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract dated 2021 noted "Subject to the Resident's needs, Premium Home Healthcare will provide the following services which are included in the basic monthly fee:	0 485		

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0 485	Continued From page 3 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by Premium Home Healthcare staff at the following times: 7:00 AM [a.m.] - 9:00 AM Breakfast 12:00 Noon - 1:30 PM [p.m.] Lunch 5:30 PM - 7:30 PM Dinner On September 18, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the choice was noted in the 6790 assessment they do with the resident and the case manager, and they could opt for no meals, one meal, two meals, or three meals per day. In addition, CNS-A stated the contract could be modified to the choices made by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	0 650		

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0 650	Continued From page 4 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (clinical nurse supervisor/CNS-A, unlicensed personnel/ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-A CNS-A started employment on January 31, 2019, under the comprehensive home care license and began providing assisted living services to residents of the facility on August 1, 2021. CNS-A's employee record lacked documented evidence of: - an annual performance review that identified	0 650		

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0 650	Continued From page 5 areas of improvement needed and training needs. ULP-C ULP-C was hired on February 4, 2023, to provide direct care services to residents of the facility. ULP-C's record lacked documented evidence of: - an annual performance review that identified areas of improvement needed and training needs; and - documented evidence of training and competency in preparing medications for unplanned times away. On September 18, 2024, at 11:10 a.m., CNS-A stated she had not completed a review on herself as the owner of the business, and stated a review was not found in ULP-C's file, and she was not sure if one had been completed or not. In addition, CNS-A stated ULP-C had been trained and competency tested for preparing medications for unplanned times away but it was not documented in her employee file. The licensee's Personnel Records policy dated August 1, 2021, noted the personnel record for each staff member would include performance reviews identifying areas of improvement and training needs. It also noted the personnel record would include records of competency evaluations and orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 660	Continued From page 6	0 660		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel/ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	0 660		

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0 660	Continued From page 7 situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated June 29, 2024, indicated the licensee was a low risk for TB transmission. ULP-C was hired on February 4, 2023, to provide direct care services to residents of the facility. ULP-C's employee record contained a TST dated read on February 8, 2023. However, the record lacked documented evidence of a second TST as required. On September 18, 2024, at 11:25 a.m., ULP-C stated she had a second TST done. Clinical nurse supervisor (CNS)-A instructed ULP-C to provide evidence of the second TST. However, no further documentation was provided. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, noted if the first-step TST was negative, a second-step TST would be administered 1-3 weeks after the first TST was read. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (serum	0 660		

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0 660	Continued From page 8 blood test). Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (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	0 680		

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0 680	Continued From page 9 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the initial tour of the facility with clinical nurse supervisor (CNS)-A on September 16, 22024, at 11:45 a.m., the surveyor observed the facility to be a four story split level home with five bedrooms, a kitchen, two living areas, and a dining room. The Emergency Preparedness Book, dated reviewed on June 24, 2024, lacked the following required content: - policy and procedure to address system of	0 680		

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0 680	Continued From page 10 medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - communication plan including a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - communication plan including a means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; - communication plan including a method for sharing information from the emergency plan, that the facility determined appropriate, with residents and their families/representatives; and - exercises to test the plan at least twice per year. On September 18, 2024, at 12:45 p.m., CNS-A and licensed assisted living director (LALD)-B stated they had systems in place but not documented as required. In addition, CNS-A stated they had completed one drill on August 16, 2024, for severe weather, but were not aware of the requirement to complete a second test. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October, 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications,	0 680		

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0 680	Continued From page 11 methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	0 730		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 12 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). 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:	0 730		

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	37678	A. BUILDING: _____ B. WING _____	09/18/2024

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0 730	Continued From page 13 R3 admitted to the facility on April 22, 2024, and discharged on August 12, 2024. R3's diagnoses included depression and dementia. R3's Service Plan dated April 24, 2024, noted services including medication administration. R3's record included a Discharge Summary dated June 11, 2024. However, it lacked the following: - a summary of the resident's stay including course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results. On September 17, 2024, at 9:05 a.m., clinical nurse supervisor (CNS)-A stated she typically included a copy of the face sheet which would include allergies, and the discharge summary lacked the above required content. In addition, CNS-A stated the resident went to a recovery unit after the hospital and did not return to the facility. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, noted a discharge summary would be completed by the registered nurse including a summary of the resident's stay, including course of illnesses, allergies, treatment, therapies, and pertinent labs and consult reports. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 14 (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 and failed to keep the facility in compliance with the Minnesota Fire Code. These deficient conditions had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 780		

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0 780	Continued From page 15 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility tour with the licensed assisted living director (LALD)-B on September 18, 2024, between 9:00 a.m. and 10:30 a.m. the following deficient conditions were observed: EMERGENCY ESCAPE WINDOW: The surveyor observed that the emergency escape window was blocked in resident room 1 by a headboard of a bed and that the cover on the window well was blocking the emergency escape window from opening in resident room 5. The surveyor explained to the LALD-B that all means of egress, including emergency escape windows shall always be maintained and free of obstructions. SMOKE ALARMS: The surveyor observed that the smoke alarms in the home were not interconnected. The surveyor explained to the LALD-B that all the smoke alarms in the facility shall be interconnected. These deficient conditions were visually verified by the LALD-B accompanying on the tour.	0 780		

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0 780	Continued From page 16 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in 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.	0 810		

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0 810	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: A record review and interview were conducted on September 18, 2024, at approximately 10:00 a.m. with the licensed assisted living director (LALD)-B on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility. FIRE SAFETY EVACUATION PLAN: During record review the surveyor observed the resident rooms were not identified on the fire safety and emergency evacuation drawings and they were not labeled on the resident room doors. Also, during record review, the surveyor observed there were no signed written agreements for the primary or secondary evacuation locations. The surveyor explained to LALD-B the fire safety	0 810		

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0 810	Continued From page 18 and evacuation drawings shall have the resident rooms labeled and that shall reflect on the fire safety and evacuation drawing and that written signed agreements shall be obtained and updated annually for primary and secondary evacuation locations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to	0 900		

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0 900	Continued From page 19 any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of two residents (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: R1's undated Assisted Living Contract was signed by R1. However, it lacked a signature by the facility and lacked a date. R1's Home Care Service Plan dated March 1, 2024, noted services including medication administration. On September 18, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated they had received a new revised contract for residents in May or June of this year but stated she had not reviewed it with R1 yet, which is why she had not signed or dated it yet. No further information was provided.	0 900		

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0 900	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of two residents (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written contract with the following required content:	0 910		

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0 910	Continued From page 21 -the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. R1's undated Assisted Living Contract indicated the licensee's Assisted Living License Number. However, it lacked the HFID number as required. R1's Home Care Service Plan dated March 1, 2024, noted services including medication administration. On September 18, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated they had received a new revised contract for residents in May or June of this year which included the license number, and added this was what was provided by the consultant. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 22 (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a	01060		

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01060	Continued From page 23 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included major depression, diabetes, and anxiety. R1's Service Plan dated June 24, 2022, noted services including medication administration. R1's Progress Notes the following hospitalizations: - February 21, 2024, through March 1, 2024; - March 5, 2024, through March 16, 2024; - April 9, 2024, through April 11, 2024; - July 7, 2024, through July 17, 2024; and - July 23, 2024, through July 27, 2024. R1's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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01060	Continued From page 24 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, the resident's record lacked documented evidence the OOLTC had been notified of hospitalizations longer than four days. On September 17, 2024, at 11:10 a.m., clinical nurse supervisor (CNS)-A stated she was not aware of the requirement to provide the emergency relocation information to the resident, the resident's representative, and legal representative, and added she was not aware of the requirement to provide written notice to the OOLTC for hospitalizations longer than four days. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, noted in the event of an emergency relocation, the facility would provide a written notice as soon as possible to the resident, legal representative and designated representative, and if the resident had not returned within four days, a copy would be provided to the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 25 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all areas of the uniform assessment tool as required per Minnesota Administrative Rule 4659.0150 were addressed for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01620		

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01620	Continued From page 26 R1's diagnoses included major depression, diabetes, and anxiety. R1's Service Plan dated June 24, 2022, noted services including medication administration. R1's Nurse Reassessment Visits dated March 18, 2024, April 16, 2024, and July 18, 2024, lacked the following required content: - sleep schedule, social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; - advanced health care directives and end-of-life preferences; - dressing, grooming, bathing, and personal hygiene; - eating, dental status, oral care, and assistive devices and dentures, if applicable; - instrumental activities of daily living including the ability to self-manage medications, housework and laundry, and transportation; - allergies and sensitivities related to medication, seasonality, environment, and food and if any are life threatening; - communication and sensory capabilities including hearing and vision; - list of treatments, including the type, frequency, and level of assistance needed; - risk factors; - who has decision-making authority for the resident including the presence of any advanced health care directive or other legal document that established a substitute decision maker and the scope of decision-making authority; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. On September 17, 2024, at 10:35 a.m., clinical nurse supervisor (CNS)-A stated she utilized the	01620		

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	37678	A. BUILDING: _____ B. WING _____	09/18/2024

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01620	Continued From page 27 uniform assessment tool for the admission assessment, but not for any of the other assessments, and stated she was not aware of the requirement to have all content reviewed for each assessment. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, noted the registered nurse (RN) would conduct a comprehensive assessment utilizing the uniform assessment tool No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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01700	Continued From page 28	01700		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R1) who received medication management services.	01700		

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01700	Continued From page 29 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: During the entrance conference on September 17, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. R1's diagnoses included major depression, diabetes, and anxiety. R1's Medication Profile dated March 13, 2024, noted medications, purpose, side effects, and interactions. However, it lacked contraindications. R1's Service Plan dated June 24, 2022, noted services including medication administration. R1's prescriber orders dated July 19, 2024, included one stool softener, and one statin to lower cholesterol. R1's September 2024 untitled medication administration record listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given. On September 19, 2024, at 11:10 a.m., CNS-A stated contraindications was not included on the	01700		

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01700	Continued From page 30 medication assessment for any resident. The licensee's Assessment of Medications policy dated August 1, 2021, noted the assessment would include indication, effectiveness, side effects, immediate desired effects, unusual and unexpected effects, drug interactions, allergic reactions, and changes in condition that contraindicate continued administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	01730		

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01730	Continued From page 31 tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01730		

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01730	Continued From page 32 During the entrance conference on September 17, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. R1's diagnoses included major depression, diabetes, and anxiety. R1's Service Plan dated June 24, 2022, noted services including medication administration. R1's prescriber orders dated July 19, 2024, included one stool softener, and one statin to lower cholesterol. R1's September 2024 untitled medication administration record listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given. R1's record lacked a medication management plan to include: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. On September 19, 2024, at 11:10 a.m., CNS-A stated she typically wrote this but for some reason it got missed for R1. The licensee's Service Plan for Medication Management policy dated August 1, 2021, noted the medication management plan would include a description of the storage of medications including resident preference, risk of diversion, and instructions per manufacturer. No further information was provided.	01730		

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01730	Continued From page 33 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were documented after administration for one of one unlicensed personnel (ULP)-C, and failed to ensure medications were administered as prescribed for one of two residents (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	01760		

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01760	Continued From page 34 situation has occurred only occasionally). The findings include: MEDICATION ADMINISTRATION DOCUMENTATION On September 16, 2024, the surveyor observed ULP-C provide medication administration to R2. ULP-C placed the medications in a medication cup, initial the medication administration record, and take the medications to R2. After completion, ULP-C stated she did sign off the medications before administering. At this time, clinical nurse supervisor arrived in the area and stated mediations are to be documented after administration, and this is how staff are trained. The licensee's Medication Documentation policy dated August 1, 2021, noted each medication administered by staff would be documented in the resident's clinical record. It noted the documentation would be complete, accurate and legible. MEDICATIONS ADMINISTERED AS PRESCRIBED R1's diagnoses included major depression, diabetes, and anxiety. R1's prescriber orders dated June 20, 2024, included Humulin KwikPen (prefilled insulin pen) take 6 units with carbohydrate containing meals, and for blood sugars 150-199 give 1 unit, 200-249 give 2 units, 250-299 give 3 units, 300-349 give 4 units, 350-399 give 5 units, above 400 give 6 units and call the prescriber. R1's Service Plan dated June 24, 2022, noted	01760		

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01760	Continued From page 35 services including medication administration. R1's untitled blood sugar and insulin administration documentation sheet noted on September 17, 2024, at 7:10 a.m., R1's blood sugar was 366, and R1 received a total of 10 units. On September 17, 2024, at 11:10 a.m., clinical nurse supervisor (CNS)-A stated R1 should have received a total of 11 units insulin including 6 units plus 5 units for the sliding scale amount. CNS-A stated R1 administered insulin independently, but staff verified the amount prior to administration by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to renew prescriptions at least every 12 months for one of two residents (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	01830		

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01830	Continued From page 36 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 record lacked an annual renewal of all prescriber orders for medications. R1's diagnoses included major depression, diabetes, and anxiety. R1's Service Plan dated June 24, 2022, noted services including medication administration. R1's September 2024 untitled medication administration included the following medications: - acetaminophen 1,000 milligrams (mg) by mouth every eight hours; and - Fleet enema unwrap and insert 1 enema rectally once a day as needed. R1's record included a prescriber order dated July 28, 2023, for the Fleet enema. On September 18, 2024, at 9:55 a.m., clinical nurse supervisor (CNS)-A stated they did not have a renewed order for either of the above medications as required, and was not sure why it was missing. The licensee's Medication Orders policy dated August 1, 2021, noted medication orders would be renewed at least every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01830		

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01830	Continued From page 37 days	01830		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of one medication storage cabinet, the licensee failed to ensure expired medications were not available for use in one of two medication carts (upstairs), and the licensee failed to ensure the medication refrigerator maintained an acceptable temperature. 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: During the entrance conference on September 16, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the	01880		

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01880	Continued From page 38 facility. UNSECURED MEDICATION STORAGE On September 17, 2024, at 10:22 a.m., the surveyor observed unlicensed personnel (ULP)-C open the medication storage cabinet for CNS-A and left the area with the keys remaining in the cabinet. CNS-A also left the area, and R1 was observed on the same level of the home with the unsecured medication cabinet. On September 17, 2024, at 10:50 a.m., CNS-A observed the keys with the surveyor and instructed ULP-C to come remove them from the cabinet. Both ULP-C and CNS-A stated that this time the keys should not be left in the cabinet, and should be kept in the locker where staff only had access. EXPIRED MEDICATION On September 18, 2024, at 11:55 a.m., in the presence of CNS-A, the surveyor observed the licensee's one medication storage cabinet. CNS-A stated they looked for expired medications on a weekly basis. The medication cabinet contained the following expired medication: - rizatriptan (medication to treat migraines) 5 milligrams (mg), labeled for R1, expired January 25, 2023. At this time, CNS-A stated the medication was expired and should be disposed of. REFRIGERATOR TEMPERATURE On September 18, 2024, at 12:10 p.m., the surveyor reviewed the kitchen refrigerator with CNS-A. The temperature was 40 degrees Fahrenheit (F). The refrigerator contained three unopened boxes and three unopened pens of Humalog KwikPen (prefilled insulin pens), one	01880		

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01880	Continued From page 39 opened Ozempic pen (medication used to lower blood sugar), and seven unopened Humulin KwikPen (prefilled insulin pens) for R1. The Daily Temperature Log Sheet for September 2024 included daily refrigerator temperatures ranging from 30 - 40 degrees F. The temperature was marked below 36 degrees F on three occasions. At this time, CNS-A stated she had noticed last week the temperature on the thermometer inside the refrigerator jumped when the door was opened, so she had ordered new thermometers that would allow for the reading of the temperature without opening the door. CNS-A stated the temperature should remain between 36 - 40 degrees F. The manufacturer's instructions for Humalog KwikPen dated 2023 noted unused pens are to be stored in the refrigerator at 36 - 46 degrees F. The manufacturer's instructions for Ozempic dated October 2022 noted unopened pens should be refrigerated at 36 - 46 degrees F. The manufacture's instructions for Humulin KwikPen dated 2022 noted unused pens should be stored in the refrigerator between 36 - 46 degrees F. The licensee's Storage/Control of Medications policy dated August 1, 2021, noted all prescription drugs would be securely locked in substantially constructed compartments according to the manufacturer's directions, and only authorized personnel would have access to the stored medications. It also noted "Medications requiring refrigeration are clearly labeled and stored in an	01880		

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01880	Continued From page 40 enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." 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 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 date time sensitive medications with an open date 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: During the entrance conference on September 16, 2024, at 10:50 a.m., clinical nurse supervisor	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37678	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIUM HOME HEALTHCARE LLC	9020 PRESTWICK PKWY NORTH BROOKLYN CENTER, MN 55443

(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 41 (CNS)-A stated the licensee provided medication management services to the residents at the facility. On September 18, 2024, at 11:55 a.m., in the presence of CNS-A, the surveyor observed the licensee's one medication storage cabinet, and noted the following: - R1's Humalog KwikPen (prefilled insulin pen) 3 milliliter (ml) lacked a date to indicate when the pen had been opened or when it would expire. At this time, CNS-A stated it was the expectation that staff date the insulin pens when they were opened. The manufacturer's instructions for use for Humalog KwikPen dated 2023 noted "Throw away the HUMALOG Pen you are using after 28 days, even if it still has insulin left in it." 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: Follow-Up
Date: *09/20/24*
Time: 15:02:00
Report: 1043241272

Food and Beverage Establishment Inspection Report

Location:
Premium Home Healthcare Llc
9020 Prestwick Pkwy North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037856
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635688828
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 previously issued on 09/17/24 have NOT been corrected.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS STORED OVER MEDICATION IN KITCHEN FRIDGE. ADVISED STAFF TO STORE RAW FOOD AT THE BOTTOM. COMPLY WITH ABOVE RULE. STAFF CORRECTED ON SITE.

Issued on: 09/17/24 *Comply By: 09/17/24*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

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

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

Follow-up report completed to assess compliance on previous order(s) from the 9/17/24 inspection with Annette Truebenbach as the lead Health Regulation Division Nurse Evaluator completing the site survey. Remaining order(s) on the current report will be assessed during the next on-site inspection.

Photo verification for the new dish machine and microwave were provided via email on 9/19/24. Per the test result of the dish machine test, the utensil surface temperature of the new dish machine reached at least 170F degrees.

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available

for same day service for highly susceptible populations, discard any leftovers by the end of the day. Staff supervision must be provided to ensure proper/safe food handling procedures and cooking temperatures if/when foods are cooked/reheated by clients.

This facility has a residential kitchen with residential equipment, wooden cabinetry, laminate flooring and countertops. Utensil surface temperature of residential dish machine must reach at least 160F degrees (or 150F degrees for NSF/ANSI 184 residential dish machine). Sanitizing option on dish machine must always be used when running a cycle.

Facility has two CFPM:
Jude C. Osakwe, FM107558, 8/29/27
Ifeyinwa Osakwe FM107559, 7/31/27

***Notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 1043241272 of 09/20/24.

Certified Food Protection Manager: Jude C. Osakwe

Certification Number: FM107558 Expires: 08/29/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ify O
RN

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

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

Type: Full
Date: *09/17/24*
Time: 10:00:00
Report: 1043241268

Food and Beverage Establishment Inspection Report

Location:
Premium Home Healthcare Llc
9020 Prestwick Pkwy North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037856
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635688828
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS STORED OVER MEDICATION IN KITCHEN FRIDGE. ADVISED STAFF TO STORE RAW FOOD AT THE BOTTOM. COMPLY WITH ABOVE RULE. STAFF CORRECTED ON SITE.

Comply By: 09/17/24

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.

DISH MACHINE AND MICROWAVE WERE OUT OF SERVICE PRIOR TO INSPECTION. NEW EQUIPMENT ORDERED AND EXPECTED TO BE DELIVERED ON 9/17/24. COMPLY WITH ABOVE RULE.

Comply By: 09/17/24

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: FRDIGE
Violation Issued: No

Type: Full
Date: *09/17/24*
Time: 10:00:00
Report: 1043241268
Premium Home Healthcare Llc

Food and Beverage Establishment Inspection Report

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

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

Inspection was completed with Annette Truebenbach as the lead Health Regulation Division Nurse Evaluator completing the site survey along with three facility staff members.

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

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations, discard any leftovers by the end of the day. Staff supervision must be provided to ensure proper/safe food handling procedures and cooking temperatures if/when foods are cooked/reheated by clients.

This facility has a residential kitchen with residential equipment, wooden cabinetry, laminate flooring and countertops. Utensil surface temperature of residential dish machine must reach at least 160F degrees (or 150F degrees for NSF/ANSI 184 residential dish machine). Sanitizing option on dish machine must always be used when running a cycle.

*Dish machine and microwave were ordered from Lowe's on 9/11/24 with 9/17/24 as the estimated date of arrival. Advised staff to continue using 3 compartment set up for dishwashing until dish machine is installed and reaching the required utensil surface temperature as noted above.

Facility has two CFPM:
Jude C. Osakwe, FM107558, 8/29/27
Ifeyinwa Osakwe FM107559, 7/31/27

***Notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

Type: Full
Date: *09/17/24*
Time: 10:00:00
Report: 1043241268
Premium Home Healthcare Llc

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1043241268 of 09/17/24.

Certified Food Protection Manager: Jude C. Osakwe

Certification Number: FM107558 Expires: 08/29/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

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