Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

July 22, 2025

Licensee
1st Assured Care LLC
4309 Marigold Avenue North
Brooklyn Center, MN 55443

RE: Initial License Number 415324
Health Facility Identification Number (HFID) 40668
Project Number(s) SL40668015

Dear Licensee:

On May 19, 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 December 18, 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 July 22, 2025.

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

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

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 PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

March 12, 2025

Licensee
1st Assured Care LLC
4309 Marigold Ave North
Brooklyn Center, MN 55443

RE: Provisional Conditional License Number 415324
Health Facility Identification Number (HFID) 40668
Project Number(s) SL40668015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 18, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the 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.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **June 10, 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 . . ."

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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $6,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - 3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - 3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional 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. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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

CONDITIONAL LICENSE ISSUED:

MDH will issue 1st Assured Care LLC a conditional provisional 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 1st Assured Care LLC is in substantial compliance.

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** 1st Assured Care LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. 1st Assured Care LLC must provide the Department:

    i. A list of the names and birthdates of any individuals 1st Assured Care LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents including:
        1. Name and birthdate of each resident
        2. Current payment source for services
        3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** 1st Assured Care LLC will contract with an RN to provide consultation concerning all resident(s) to whom 1st Assured Care LLC provides provisional licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from 1st Assured Care LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with 1st Assured Care LLC and MDH must review the RN's credentials and approve the selection. 1st Assured Care LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to 1st Assured Care LLC in an effort to help 1st Assured Care LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. 1st Assured Care LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies 1st

Assured Care LLC and the RN consultant about a change. Each report will be electronically submitted to: Brandon Mueller, State Evaluation Team, Health Regulation Division, at brandon.w.mueller@state.mn.us and can be reached at 651-247-2064 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of 1st Assured Care LLC to correct the violations cited during the survey as well as to determine the overall practice of 1st Assured Care LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

f. **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.

g. **Corrective Action Plan:** 1st Assured Care LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if 1st Assured Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines 1st Assured Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to 1st Assured Care LLC. If MDH determines 1st Assured Care LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Casey DeVries directly at: 651-201-5917.

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
	40668	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST ASSURED CARE LLC	4309 MARIGOLD AVE 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
0 000	Initial Comments 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: SL40668015-0 On December 16, 2024, through December 18, 2024, the Minnesota Department of Health conducted an initial survey at the above provider. At the time of the survey, there were two residents; both received services under the Assisted Living Facility provisional license. An immediate order for correction was identified on December 17, 2024, issued for SL40668015-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employment of an assisted living director (ALD) licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents receiving Assisted Living services. 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 included: On December 16, 2024, at approximately 9:49 a.m., owner (O)-D stated assisted living director in residency (ALDIR)-A was the licensee's ALD prior to their residency permit expiring in November. O-D stated housing manager (HM)-B applied for a residency permit with BELTTS however, HM-B was waiting on approval due to fingerprinting. O-D stated clinical nurse supervisor (CNS)-C was a LALD but not for the licensee however, CNS-C was ALDIR-A's mentor and would be HM-B's mentor. The surveyor observed the BELTTS website which indicated	0 110		

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0 110	Continued From page 2 the following: - ALDIR-A's residency permit director started November 28, 2023, and expired on November 27, 2024; - HM-B was not listed on the BELLTS website; and - CNS-C held an assisted living director license with an expiration date of October 31, 2025, and was listed as the director of record at three other facilities. CNS-C's employee record included an Independent Contractor Agreement signed November 6, 2023, and indicated the following job responsibilities for CNS-C: - administering medications and treatments as prescribed; - monitoring residents' health and reporting significant changes; - assisting with resident care plans; - documentation of care and services provided; - providing general care services to residents, including but not limited to wound care, IV administration, and assessments; and - training and supervision of unlicensed staff. On December 16, 2024, at 10:13 a.m., CNS-C stated they were not the LALD for the licensee. CNS-C stated ALDIR-A was "working" on taking the BELTTS exam and HM-B applied for a residency permit. CNS-C stated they could assist the licensee with questions however, they worked as a director at another facility. CNS-C stated they were just providing nursing services for the licensee including medication management, assessment, and was on call for questions 24 hours per day. On December 17, 2024, at 12:28 p.m., O-D stated, "I don't know who would be as a director."	0 110		

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0 110	Continued From page 3 O-D stated HM-B's application was approved for a residency permit. CNS-C stated they would be mentoring HM-B when they received their residency permit, however BELTTS had not sent the paperwork to complete for becoming the mentor. The licensee's Shared Assisted Living Director and Delegation of Authority policy September 6, 2024, indicated an assisted living director was the person who administers, manages, supervises, or is in general administrative charge of an assisted living facility. Only an individual who was qualified as a licensed assisted living director and who holds a valid license for the current licensure period may use the title licensed assisted living director. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;	0 470		

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0 470	Continued From page 4 (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 have a daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required. 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 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: On December 16, 2024, at approximately 10:32 a.m., during a facility tour, the surveyor did not observe a posted staff schedule. Clinical nurse supervisor (CNS)-C and owner (O)-D both stated	0 470		

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0 470	Continued From page 5 the staff schedule was normally kept inside the medication cabinet. The secured medication cabinet was opened, and the surveyor did not observe the staff schedule. CNS-C stated the schedule was in the medication cabinet last time they were at the facility. O-D stated they would print a new staff schedule. On December 16, 2024, at 2:16 p.m., CNS-C stated it was O-D's responsibility to post the staff schedule. The licensee's Staffing policy dated September 6, 2024, indicated the schedule was posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) 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	0 480		

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0 480	Continued From page 6 supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 7 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 December 16, 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.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and	0 485		

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0 485	Continued From page 8 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. The facility must not require a resident to include and pay for meals in the resident's contract. 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 for one of one resident (R1). 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: R1 admitted to the licensee on August 16, 2024, and began receiving assisted living services. R1's Assisted Living Contract dated August 16, 2024, included a section titled Primary Services and indicated, "Subject to the Resident's needs, [name of licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served	0 485		

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0 485	Continued From page 9 in the dining area as planned and prepared by [name of licensee] staff at the following times: 8:00 AM Breakfast 12:00 PM Lunch 5:00 PM Dinner" The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee. On December 17, 2024, at 12:38 p.m., owner (O)-D stated all residents received the same contract as R1. O-D stated the licensee hired a consultant to assist with the writing of the contract. O-D stated they knew meals could not be included in a base fee however, when they read the contract, they believed the section above pertained to waivered services covering the resident's meals. O-D stated the licensee did not charge for meals. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult	0 550		

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0 550	Continued From page 10 Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required information related to the licensee's grievance procedure including contact information for the Office of Mental Health and Developmental Disabilities (OOMHDD). 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 client'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 December 16, 2024, at 10:32 a.m., during a facility tour, the surveyor observed there was no evidence of the contact information for OOMHDD. Owner (O)-D stated the licensee completed a mock survey and they did not receive any information regarding OOMHDD's phone number needing to be posted. O-D stated they would post the number. On December 16, 2024, at 2:17 p.m., clinical nurse supervisor (CNS)-C stated they did not	0 550		

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0 550	Continued From page 11 know the OOMHDD phone number was required to be posted at the facility. CNS-C stated they knew OOLTC phone number was required to be posted. The licensee's Grievance policy dated September 6, 2024, indicated the contact information for OOMHDD would be posted conspicuously in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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 available to all residents. Staff who have not received emergency and disaster training are	0 680		

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0 680	Continued From page 12 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's emergency disaster preparedness plan binder dated May 30, 2024, lacked evidence of the following required content: - strategies for addressing facility & community-based risks to include staffing shortages; - quarterly review of the missing resident plan; - policies and procedures including evacuation to include an alternate evacuation location; - names and contact information to include local emergency services, resident's physicians, and volunteers; and - emergency prep testing requirements. On December 17, 2024, at 12:40 p.m., owner	0 680		

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0 680	Continued From page 13 (O)-D stated they demonstrated all emergency drills during the emergency preparedness plan training. O-D stated they documented the emergency drills under training verses drills performed and did not have documentation to show the emergency drills were conducted. O-D stated the alternative location for evacuation would be their house however, they entered the same location by accident for primary and alternative evacuation site. Clinical nurse supervisor (CNS)-C stated they reviewed the missing resident policy annually and was not aware of the requirement to review the policy quarterly. O-D stated if there was a staffing shortage they would call the staff that did not work as frequently to come in. The licensee's Emergency Preparedness policy dated September 6, 2024, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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;	0 780		

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0 780	Continued From page 14 (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 comply with the current Minnesota Fire Code provisions. This deficient condition 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 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 December 17, 2024, at approximately 12:30 p.m., survey staff toured the facility with owner (O)-D. During the tour it was observed the dryer	0 780		

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0 780	Continued From page 15 vent was disconnected from the clothes dryer. The surveyor explained to O-D the potential hazard the disconnected dryer vent presented. O-D stated they understood the deficiency. 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) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	0 810		

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0 810	Continued From page 16 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 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) 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 December 17, 2024, at approximately 12:30 p.m., survey staff observed the fire evacuation diagrams indicated the facility was using the garage as a designated exit out of the facility. The survey staff explained exiting through the garage is not allowed and the hazards it presents. On December 17, 2024, owner (O)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following:	0 810		

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0 810	Continued From page 17 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On December 17, 2024, at 1:30 p.m., O-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The	01640		

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01640	Continued From page 18 facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for two of two residents (R1, R2). 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: R1 R1 admitted to the licensee on August 16, 2024, and began receiving assisted living services.	01640		

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01640	Continued From page 19 On December 17, 2024, at 1:22 p.m., the surveyor observed housing manager (HM)-B look at a phone application for R1's blood glucose level, which was 233 milligrams per deciliter (mg/dl). HM-B stated R1 needed their sliding scale insulin because their blood glucose was over 200 mg/dl. HM-B opened RTasks (a documenting software program) on the computer, opened the as needed (PRN) medication section, and documented the blood glucose level in the notes section. R1's Individualized Treatment and Therapy Plan as of December 16, 2024, included blood glucose three times per day and instructed "using the resident phone go to libre 3, scan resident sensor on the arm to check blood glucose and record before breakfast, before lunch, and before dinner. Follow the sliding scale for insulin lispro if BS (blood sugar) is above 200." R1's service plan titled Addendum to Contract - Waiver - MN signed August 16, 2024, indicated R1 received assistance with appointments, bathing, grooming, housekeeping, incontinent care, meals, laundry, medication administration, mobility with wheelchair, and vital sign monitoring. R1's service plan lacked blood glucose monitoring. R2 R2 admitted to the licensee on October 31, 2024, and began receiving assisted living services. R2's Individualized Treatment and Therapy plan as of December 17, 2024, included blood glucose two times per day and instructed "using freestyle meter, check and record glucose level every morning and bedtime. If freestyle libre 2 not working use manual way".	01640		

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01640	Continued From page 20 R2's Service Recap Summary - Month dated December 1, 2024, through December 31, 2024, indicated R2's blood glucose was monitored by the licensee's staff December 1, 2024, through December 16, 2024, twice per day in the morning and evening. R2's service plan titled Addendum to Contract - Waiver - MN signed October 31, 2024, indicated R2 received assistance with appointments, bathing, dressing, grooming, socialization, housekeeping, laundry, meals, medication administration, vital sign monitoring, shopping assistance, and transportation. R2's service plan lacked blood glucose monitoring. On December 17, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-C and owner (O)-D both stated R1 and R2 received blood glucose monitoring as a service. The surveyor inquired why R1 and R2's service plan lacked blood glucose monitoring as a service. CNS-C stated it must have been a computer glitch. The licensee's Service Plan policy dated September 6, 2024, indicated the service plan must be revised, if needed, based on resident review or reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 21 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 administered according to manufacturer's instructions 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 admitted to the licensee on August 16, 2024, and began receiving assisted living services. R1's diagnoses included type two diabetes with diabetic polyneuropathy (nerve disease) and diabetic retinopathy with macular edema (retina becomes swollen due to fluid leakage causing	01760		

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01760	Continued From page 22 vision loss). R1's service plan titled Addendum to Contract - Waiver - MN signed August 16, 2024, indicated R1 received assistance with appointments, bathing, grooming, housekeeping, incontinent care, meals, laundry, medication administration, mobility with wheelchair, and vital sign monitoring. On December 17, 2024, at 1:22 p.m., the surveyor observed housing manager (HM)-B look at a phone application for R1's blood glucose level, which was 233 milligrams per deciliter (mg/dl). HM-B stated R1 needed their sliding scale insulin because their blood glucose was over 200 mg/dl. HM-B opened RTasks (a documenting software program) on the computer, opened the as needed (PRN) medication section, and documented the blood glucose level in the notes section. HM-B then sanitized their hands, applied gloves, took the insulin out of the secured medication cabinet, cleaned R1's left lower abdomen, applied a needle to the insulin pen, and dialed the insulin lispro KwikPen pen to 2 units (u). Without priming the insulin pen, HM-B administered the 2 u of insulin lispro to R1's left lower abdomen. HM-B stated they were trained to prime the insulin pen prior to dialing the prescribed dose on the insulin pen however, they felt under pressure and "missed the step." Clinical nurse supervisor (CNS)-C, who was also present for the interview, stated they trained unlicensed personnel (ULP) to prime the insulin pen to ensure it was patent prior to administering insulin. The manufacturer's instructions for insulin lispro KwikPen dated 2023, recommended the insulin pen be primed before each injection. "Priming your Pen means removing the air from the Needle and Cartridge that may collect during	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40668	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST ASSURED CARE LLC	4309 MARIGOLD AVE NORTH BROOKLYN CENTER, MN 55443

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01760	Continued From page 23 normal use and ensures that the Pen is working correctly." "If you do not prime before each injection, you may get too much or too little insulin." In addition, to prime an insulin pen turn the dose knob to select 2 u, with the needle pointing up tap the cartridge holder gently to collect air bubbles to the top, and then press the dose know until it stops at zero. The licensee's 7.36 Insulin policy dated August 1, 2021, did not address the administration of insulin pens. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 store prescription medication securely to permit only authorized personnel to have access. In addition, the licensee failed to monitor the temperature of a medication refrigerator used to store prescription medications 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	01880		

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01880	Continued From page 24 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 December 16, 2024, at 10:32 a.m., during a facility tour, the surveyor observed the following medication in the unsecured kitchen refrigerator: - seven insulin lispro KwikPens for R1; and - two Lantus Solostar pens for R1. Owner (O)-D stated the licensee kept track of refrigerator temperatures on a paper document located on the kitchen refrigerator. The surveyor observed no refrigerator temperature log on the kitchen refrigerator. O-D stated the refrigerator temperature log was currently "missing", and they were unsure what happened to the document. The surveyor also observed a thermometer reading 49 degrees; however the refrigerator had recently been opened to put away groceries. In addition, the surveyor inquired why the insulin pens listed above were unsecured in the kitchen refrigerator. O-D stated there was a cover that went over the drawer in the refrigerator and they believed "it would count" for securing the medications. On December 16, 2024, at 2:17 p.m., clinical nurse supervisor (CNS)-C stated medications were to be stored in the locked medication cabinet. CNS-C stated they kept refrigerated medications in the kitchen refrigerator and the licensee had discussed purchasing a mini refrigerator to store medication securely, but they did not have one yet.	01880		

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01880	Continued From page 25 The manufacturer's instructions for Lantus dated November 2018, indicated unopened Lantus Solostar pens should be refrigerated at a temperature of 36 degrees Fahrenheit (F) to 46 degrees F until opened or expired. The manufacturer's instructions for insulin lispro dated December 2015 indicated unopened insulin lispro KwikPen should be refrigerated at a temperature of 36 degrees F to 46 degrees F until opened or expired. The licensee's Storage/Control of Medications policy dated September 6, 2024, indicated when the licensee was providing medication storage outside of the residents private living space, all prescription drugs would be securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by:	02290		

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02290	Continued From page 26 Based on observation, interview, and record review, the licensee limited the rights of the residents who resided in the facility when the licensee required residents not to consume or possess alcohol within the facility. This had the potential to affect all resident residing in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 December 16, 2024, at 10:32 a.m., the surveyor observed three signs in the facility that read, "This House is An Illegal Drug, Alcohol Free Home." On December 17, 2024, at 1:57 p.m., owner (O)-D stated they knew they could not post rules to ban alcohol. O-D stated they noticed the signs in the facility and were going to change the signs to remove alcohol. O-D stated they recently attended a meeting which told them the facility could not ban alcohol however, they did not know they could not ban alcohol prior to the meeting. Housing manager (HM)-B stated they removed all the signs around the facility. The licensee's undated Minnesota Bill of Rights for Assisted Living indicated residents have the right to individual autonomy, initiative and independence in making life choices. No facility may request or require that any resident waive	02290		

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02290	Continued From page 27 any of these rights at any time for any reason, including as a condition of admission to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) who utilized bed rails. 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: R1 admitted to the licensee on August 16, 2024,	02310	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

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02310	Continued From page 28 and began receiving assisted living services. R1's diagnoses included traumatic subdural hemorrhage (bleeding of brain caused by a head injury), diabetes mellitus type two with diabetic polyneuropathy (nerve disease) and diabetic retinopathy with macular edema (retina becomes swollen due to fluid leakage causing vision loss), severe protein-calorie malnutrition, orthostatic hypotension (a drop in blood pressure with sitting or standing), depressive disorder, dementia, psychotic disturbance, anxiety, cognitive communication deficit, muscle wasting atrophy, and chronic obstructive pulmonary disease. R1's service plan titled Addendum to Contract - Waiver - MN signed August 16, 2024, indicated R1 received assistance with appointments, bathing, grooming, housekeeping, incontinent care, meals, laundry, medication administration, mobility with wheelchair, and vital sign monitoring. On December 16, 2024, at approximately 10:30 a.m., during a facility tour, the surveyor observed R1's bed had bilateral (two sides) quarter rail hospital-style bed rails located at the head of the hospital bed. R1's ongoing assessment dated October 14, 2024, indicated R1 had a standard bed and no assistive devices were needed for the bed. R1's medical record lacked: - an individualized bed rail assessment; - documentation of the purpose and intention of the bed rail including consideration whether the bed rail has the effect of being an improper restraint; - documentation of the resident's preferences;	02310		

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02310	Continued From page 29 - documentation physical inspection of the bed rails for areas of entrapment, stability, and correct installation per manufacturer's guidelines; - documentation the licensee explained the risk versus benefits of the bed rail usage with the resident and/or the resident's representative; and - documentation of the bed rail zones of entrapment measurements. On December 17, 2024, at 8:41 a.m., clinical nurse supervisor (CNS)-C stated if a resident had a bed rail, they would complete an assessment according to the food and drug administration (FDA) seven zones. CNS-C stated they currently had no bed rails at the facility. The surveyor discussed their observation of bed rails on R1's bed. CNS-C stated they did know R1 had a bed rail. CNS-C stated they were going to conduct an assessment of the bed rail on R1's next 90-day assessment. On December 17, 2024, at 8:43 a.m., owner (O)-D stated R1 received bed rails two weeks ago. On December 17, 2024, at 9:40 a.m., CNS-C stated housing manager (HM)-B notified them when R1's bed rails came to the facility. CNS-C stated they came to the facility and measured the bed rails at that time and was going to update the assessment when they completed the 90-day nursing assessment. CNS-C stated they did not complete a risk and benefit with R1 however, the hospital staff discussed the risk and benefits with R1. The Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) dated December 13, 2024, read, "To ensure an individual is an appropriate	02310		

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02310	Continued From page 30 candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail is securely attached to the bed frame per manufacturer guidelines. This includes consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc." In addition, the document read, "Even when bed rails are used according to manufacturer's guidelines, they can present a hazard. The licensee must ensure the resident and/or resident's responsible party has been educated on the risk for injury up to and including death due to entrapment." The FAQ indicated a bed rail assessment for hospital-style bed rails should include but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. In addition, the Minnesota Department of Health (MDH) document titled Resources & Frequently -	02310		

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02310	Continued From page 31 Asked Questions (FAQs) dated December 13, 2024, read "If any aspect of patient care is not documented, it is viewed as not having been completed." The March 10, 2006, FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA's, A Guide to Bed Safety, dated December 11, 2017, indicated following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's 1.11 Siderails policy dated August 1, 2021, indicated it was the responsibility of the licensee to: - assess the resident's cognitive and physical abilities, including their ability to call for help if entrapment occurs; - assess compliance with and maintain the siderails, according to manufacturer's instructions and the 2006 FDA guidance; and - educate the resident and/or representative on the risk of entrapment, including injury and death.	02310		

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02310	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to 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: On December 12, 2024, at 10:32 a.m., during a facility tour, the surveyor did not observe a posted	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 33 electronic monitoring notice throughout the facility. Owner (O)-D stated the licensee completed a mock survey and the consultant told them to remove the electronic monitoring sign because their facility had no cameras. O-D opened a file cabinet drawer and the surveyor observed two laminated electronic monitoring signs. The surveyor then observed housing manager (HM)-B post the sign at the main entrance. The licensee's Electronic Monitoring policy dated September 6, 2024, indicated the licensee would post a sign at each facility entrance accessible to visitors that stated, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *12/16/24*
Time: 11:30:00
Report: 1043241367

Food and Beverage Establishment Inspection Report

Location:
1ST ASSURED CARE LLC
4309 MARIGOLD AVENUE NORTH
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0043836
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

7-200 Toxic Supplies and Applications

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

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

1. CHLORINE SANI SPRAY BOTTLE MEASURED +200 PPM. STAFF CORRECTED TO 50 PPM. 2. BLEACH BOTTLE LABELED "FRESH SCENT". ADVISED STAFF TO PROVIDE SANITIZER THAT IS UNSCENTED AND APPROVED FOR FOOD CONTACT SURFACES. COMPLY WITH ABOVE RULE.

Comply By: 12/16/24

4-300 Equipment Numbers and Capacities

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

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

FACILITY USES CHLORINE SANTIZER. NO TEST KIT AVAILABLE. ADVISED STAFF TO PROVIDE AND MAINTAIN CHLORINE CONCENTRATION BETWEEN 50-100 PPM. COMPLY WITH ABOVE RULE.

Comply By: 12/16/24

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

CHLORINE SANITIZER SPRAY BOTTLE OBSERVED UNLABELED. ADVISED STAFF TO LABEL. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Type: Full
Date: *12/16/24*
Time: 11:30:00
Report: 1043241367
1ST ASSURED CARE LLC

Food and Beverage Establishment Inspection Report

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Chlorine: = +200 PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE
Violation Issued: No

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE*
Violation Issued: No

Food and Equipment Temperatures

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

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

Process/Item: DELI MEAT
Temperature: 45 Degrees Fahrenheit - Location: FRIDGE - COOLING
Violation Issued: No

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

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

Discussed highly susceptible populations, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, 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.

This facility has a residential kitchen with residential equipment and wooden cabinetry. Utensil surface temperature of 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.

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

***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.

Type: Full
Date: *12/16/24*
Time: 11:30:00
Report: 1043241367
1ST ASSURED CARE LLC

Food and Beverage Establishment Inspection Report

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 1043241367 of 12/16/24.

Certified Food Protection Manager: Amin Bashir

Certification Number: FM123621 Expires: 12/28/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Amin Bashir
PIC

Signed: Blia Lor

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