Electronically Delivered

August 26, 2024

Licensee
Vaimar Suites LLC
6050 68th Avenue North
Brooklyn Park, MN 55429

RE: Project Number(s) SL36789015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 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.

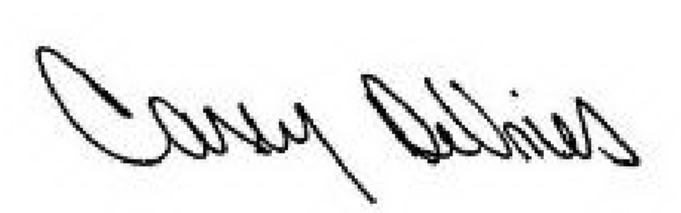
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36789	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAIMAR SUITES LLC	6050 68TH AVENUE NORTH BROOKLYN PARK, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36789015-0 On July 22, 2024, through July 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 23, 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.	0 480		
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	0 660		

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0 660	Continued From page 2 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (licensed practical nurse (LPN)-E). 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: LPN-E began employment with the licensee on March 21, 2024, to provide direct cares and	0 660		

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0 660	Continued From page 3 services to residents. LPN-E's employee recorded included a health history and symptom screening and step-one TST completed on April 22, 2024, however lacked a second step TST. On July 24, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-C stated LPN-E did not have a second step TST completed. CNS-C stated they were supposed to ensure a second step was completed but it was overlooked. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The licensee's 8.16 Tuberculosis Screening policy dated November 28, 2023, read, "Staff Screening Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with	0 660		

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0 660	Continued From page 4 residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	0 780		

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0 780	Continued From page 5 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 maintain and provide interconnected smoke alarms in the home as required for proper notification. This had the potential to affect the resident in sleeping room 5. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 23, 2024, approximately from, 9:30 a.m. to 10:45 a.m., survey staff toured the home with the licensed assisted living director (LALD)-D. During the tour, survey staff observed the LALD-D tested the smoke alarm inside resident sleeping room 5 and the smoke alarm sounded local but failed to activate the other smoke alarms in the home to operate and sound throughout as required for proper notification. Survey staff explained to the LALD-D that the interconnection of smoke alarms applies to all smoke alarms in the resident bedrooms including resident room 5 and the hallways. The LALD-D verified the finding at the time of discovery. On July 23, 2024, at approximately noon, during	0 780		

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0 780	Continued From page 6 the interview, the LALD-D, the clinical nurse supervisor-C, and the housing manager-A understood and acknowledged the above deficient finding at the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 7 The findings include: On July 23, 2024, approximately from, 9:30 a.m. to 10:45 a.m., survey staff toured the home with the licensed assisted living director (LALD)-D. During the tour, survey staff observed the following: -Excessive storage of furniture, personal belongings, and a dog (chained) under the deck outside of the window of resident room 5, indicating the grounds are not maintained. Survey staff asked the LALD-D about the excessive material under the deck and the LALD-D explained they have an unwanted individual living under the deck and have continued to take actions to resolve the situation with law enforcement. The LALD-D provided photos of local enforcement officers previously on site and the eviction court document approved by the Hennepin District Court Judge, dated, July 15, 2024. The LALD-D further explained that reported the pet to animal control. -Excessive storage of broken air conditioning units and lawnmowers outside near the deck steps, indicating the grounds are not maintained. The LALD-D stated that he would remove the broken equipment. -Inside the resident sleeping room 3, the window was missing a window screen to prevent entry of flies and insects when window is opened. -Inside resident sleeping room 4, the wood flooring behind and along the furniture was sticky and dirty. The LALD-D stated that the resident often does not allow staff inside the room. -Inside the mechanical room, the water softener tank had salt filled to the top indicating the water softener was no longer working and not maintained.The LALD-D stated that they were	0 800		

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0 800	Continued From page 8 looking to replace the water softener. The above deficient findings were verified by the LALD-D at the time of discovery on the home tour. On July 23, 2024, at approximately noon, during the interview, the LALD-D, the clinical nurse supervisor-C, and the housing manager-A understood and acknowledged the above deficient findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (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	0 810		

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0 810	Continued From page 9 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, approximately from, 9:30 a.m. to 10:45 a.m. survey staff toured the home with	0 810		

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0 810	Continued From page 10 the licensed assisted living director (LALD)-D and observed incorrect signage installed above the garage door and the sliding patio doors designated as an approved exit. Survey staff explained to the LALD-D that all exits must be maintained and be readily accessible during an emergency if the doors are considered approved exits. In addition, the garage is considered a hazardous area and when there is a power failure, the garage overhead door will not open for the residents to exit and pose an unsafe exit route. The LALD-D concurred with the finding at the time of discovery as the LALD-D stated that they would remove the signage above the garage and review their evacuation floor plan for accuracy. On July 23, 2024, at approximately noon, document and record review and interview on the home's fire safety and evacuation plan (FSEP), undated, with the LALD-D, the clinical nurse supervisor (CNS)-C, and the housing manager (HM)-A indicated the following: -The FSEP plan lacked the required resident fire protection procedures in case of a fire or similar emergency. No documentation was provided or available for review. - Record review indicated the licensee failed to provide the required annual evacuation training to residents capable of self-assisting during an evacuation. The LALD-D was not able to provide documentation showing any training offered to residents at least once per year on the FSEP. -Record review indicated the licensee did not complete all required employee FSEP training at least twice a year, after new hire orientation. The record indicated one staff training on FSEP, dated, April 12, 2023, no records were provided or available for the calendar year 2022.	0 810		

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0 810	Continued From page 11 -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills for calendar years 2022 and 2023, consisting of twice per year per shift, with at least one evacuation drill every other month, totaling a minimum of six evacuation drills per year. Record review indicated two drills were conducted for the calendar year 2023 and no drill record was available or provided for review for 2022. The above deficient findings were verified and acknowledged by the LALD-D, the CNS-C, and HM-A at the time of discovery during the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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.	01760		

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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
01760	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately setup medications, and document medication administration for one of two residents (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) 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: R2's Service Plan dated May 3, 2024, indicated R2 received medication management services. R2's physician order signed and dated by R2's medical provider on May 14, 2024, indicated R2 had the following medication orders: - certavite Tablet (tab) senior take 1 tab by mouth daily; - one- Daily tab multi-vitamin take one tablet by mouth once daily with food; - vitamin D3 50 microgram (mcg) tabs take 1 tab by mouth daily; - benztropine 1 mg tabs, take one tablet by mouth at bedtime; - clozapine tab 200 mg, take two tablets (400 mg) by mouth at bedtime; - escitalopram tab 10 mg, take one tablet by mouth once daily along with 20 mg for total dose of 30 mg; - escitalopram tab 20 mg, take one tablet by mouth once daily along with 10 mg for total dose of 30 mg;	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36789	A. BUILDING: _____ B. WING _____	07/24/2024

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VAIMAR SUITES LLC	6050 68TH AVENUE NORTH BROOKLYN PARK, MN 55429

(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
01760	Continued From page 13 - docusate Sodium capsule (CAP) 100 mg, take 1 cap by mouth twice daily; - levetiracetam 500 mg tab, take one tab by mouth twice daily; - risperidone tab 4 mg, take 1 tab by mouth twice daily; - risperidone tab 2 mg, take 1 tab by mouth at hours of sleep to make a total of 6 mg at bedtime; and - melatonin 3 mg by mouth for sleep. MEDICATION ADMINSTRATION On July 23, 2024, at 8:45 a.m., the surveyor observed R2's medication administration performed by unlicensed personal (ULP)-B. ULP-B opened a medication cabinet and retrieved a pill box, preset by the nurse, and a pharmacy prepackaged and labeled medication in a small plastic bag. ULP- B verified the medication label on the prepackaged plastic bag against the electronic medication administration record (eMAR). The prepackaged medication bag contained the following medications: - risperidone 4 mg; - levetiracetam 500 mg; and - docusate 100 mg. ULP-B put a check mark next to the above listed three medications and opened the Tuesday morning slot of the pill box which contained four unknown pills. ULP-B stated, since there was no medication name there was no way for them to identify the pills, therefore they count the pills on the eMAR, and verify that the number matches with the number of pills in the pill slot for Tuesday morning. ULP-B then counted one, two, three, four on the eMAR and stated they also had four pills in the slot. ULP-B dumped the medications into a medication cup and attempted to put a check mark next to the medication orders on the eMAR. The surveyor intervened and asked the	01760		

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	36789	A. BUILDING: _____ B. WING _____	07/24/2024

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01760	Continued From page 14 ULP-B to recount the pills on the eMAR. ULP-B recounted and stated it was three instead of four. ULP-B then stated they notify the nurse when they encounter these kind of medication discrepancies. The surveyor observed clinical nurse supervisor (CNS)-C bring R2's medication bottles to the table to identify the medications in the cup. CNS-C stated there was a 20 mg escitalopram in the pill slot which was supposed to be given to R2 in the evening along with escitalopram 10 mg. Surveyor observed a pharmacy prepackaged bubble pack containing 10mg escitalopram labeled for evening administration time. CNS-C verified that the morning pill slot for the rest of the weekdays also contained escitalopram 20mg. DOCUMENTATION On July 23, at 8:57 a.m., the surveyor observed R2's medication card for escitalopram 20 mg tablet dispensed by the pharmacy on July 1, 2024, with a pharmacy sticker indicating administration time "Morning". R2's Medication Administration Report for July 1, 2024, to July 22, 2024, indicated R2 took Escitalopram 20 mg tab along with 10 mg tab at 6:00 p.m., daily. On July 24, 2024, at 11:02 a.m., LPN-E stated the medication was received late from the pharmacy and they did the medication setup according to the pharmacy label and put escitalopram 20 mg in the morning pill slot. They did not double check the label against the physician order. Since the medication card was delivered on July 1, 2024, the surveyor inquired if LPN-E had been setting up the medication in the morning slot since July 1. LPN-E stated, "I will not say yes, or no, this Saturday [the 20th of July 2024] is when I set it up wrong for sure." Surveyor observed the morning pill slots for Sunday, and Monday were empty,	01760		

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01760	Continued From page 15 and the pill slots for the rest of the week also contained escitalopram 20 mg. On July 24, 2024, at 11:15 a.m., CNS-C stated their expectation for medication administration and documentation was that the ULPs reconcile the pharmacy prepackaged medications with labels against the eMAR first, and then count the medications in the pill slots to ensure the count matches the medication count on the eMAR. The licensee's 7.08 Medication Management-Administration & Setup policy dated November 28, 2023, read: " POLICY: The nursing staff and unlicensed personnel trained to provide medication administration at Cosmo Home Healthcare Services will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided. PROCEDURE: 1. Documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed. 2. Medication reminders will be documented on the medication administration record (MAR) by entering the unlicensed personnel (ULP) initials under "medication reminder" and include the full signature and title of the person who provided the medication reminder. 3. Assistance with medication and medication administration will be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and title of the person who provided the medication administration.	01760		

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01760	Continued From page 16 4. For medication reminders or administration, the documentation must include the medication name, dosage, date and time administered, and method and route of administration. 5. For active assistance with medications from the dosage box system, the ULP will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, dosage, date, and time administered. It will also include the purpose of the medication and any special instructions if applicable. 6. The licensed nurse who sets up the medications in the dosage box will observe and monitor the past week's medication administration documentation and compliance and will initial that this has been done. The medication regimen will also be updated and reviewed at the same time of medication set up. 7. The licensed nurse who sets up the medications will also be observant of any problems regarding storage of medications. 8. A licensed nurse will set up medications in dosage boxes for the resident, usually on a weekly basis, and will make or direct changes between set ups when necessary. ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile. If any question of medication accuracy in the dosage box arises, the unlicensed staff will contact the licensed nurse and receive direct instructions on handling any necessary changes at that time, while in direct contact with the nurse. 9. ULP will chart in each resident's medication administration record any problems with medication administration, including refusals. 10. ULP will also document any reason why medication administration was not completed as	01760		

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01760	Continued From page 17 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. 11. If initials are being used on a MAR, then a signature page must be used that includes the person's name, title, signature, and initials located in an accessible place as verification." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of a medication setup was accurate for one of two residents (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 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	01770		

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01770	Continued From page 18 situation has occurred only occasionally). The findings include: R2's Service Plan dated May 3, 2024, indicated R2 received medication management services. On July 23, 2024, at 8:45 a.m., the surveyor observed R2's medication administration performed by unlicensed personal (ULP)-B. ULP-B opened a medication cabinet and retrieved a pill box, preset by the nurse, and a pharmacy prepackaged and labeled medication in a small plastic bag. ULP- B verified the medication label on the prepackaged plastic bag against the electronic medication administration record (eMAR). The prepackaged medication bag contained the following medications: - risperidone 4 mg; - levetiracetam 500 mg; and - docusate 100 mg. ULP-B put a check mark next to the above listed three medications and opened the Tuesday morning slot of the pill box which contained four unknown pills. ULP-B stated, since there was no medication name there was no way for them to identify the pills, therefore they count the pills on the eMAR, and verify that the number matches with the number of pills in the pill slot for Tuesday morning. ULP-B then counted one, two, three, four on the eMAR and stated they also had four pills in the slot. ULP-B dumped the medications into a medication cup and attempted to put a check mark next to the medication orders on the eMAR. The surveyor intervened and asked the ULP-B to recount the pills on the eMAR. ULP-B recounted and stated it was three instead of four. ULP-B then stated they notify the nurse when they encounter these kind of medication discrepancies. The surveyor observed clinical	01770		

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01770	Continued From page 19 nurse supervisor (CNS)-C bring R2's medication bottles to the table to identify the medications in the cup. CNS-C stated there was a 20 mg escitalopram in the pill slot which was supposed to be given to R2 in the evening along with escitalopram 10 mg. Surveyor observed a pharmacy prepackaged bubble pack containing 10mg escitalopram labeled for evening administration time. CNS-C verified that the morning pill slot for the rest of the weekdays also contained escitalopram 20mg. R2's physician order signed and dated by R2's medical provider on May 14, 2024, indicated R2 had the following medication orders: - escitalopram tab 10 mg, take one tablet by mouth once daily along with 20 mg for total dose of 30 mg; - escitalopram tab 20 mg, take one tablet by mouth once daily along with 10 mg for total dose of 30 mg; R2's medication administration record (MAR) set up by the licensed practical nurse (LPN)-E for the month of July 2024, lacked accuracy for one of R2's prescribed medication escitalopram 20 milligram (mg) tablet which led to wrong administration time and wrong documentation. R2's medication administration record for the month of July indicated escitalopram 20 mg was set up for AM administration time by LPN-E on July 6, and escitalopram 20 mg was set for 8:00 p.m., administration time by LPN-E on July 13 and July 20, 2024. On July 23, at 8:57 a.m., the surveyor observed R2's medication card for escitalopram 20 mg tablet dispensed by pharmacy on July 1, 2024, with a pharmacy sticker indicating administration time "Morning". R2's Medication Administration	01770		

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01770	Continued From page 20 Report for July 1, 2024, to July 22, 2024, indicated R2 took Escitalopram 20 mg tab along with 10 mg tab at 6:00p.m., daily. On July 24, 2024, at 11:02 a.m., LPN-E stated the medication was received late from the pharmacy and they did the medication setup according to the pharmacy label and put escitalopram 20 mg in the morning pill slot. They did not double check the label against the physician order. Since the medication card was delivered on July 1, 2024, the surveyor inquired if LPN-E had been setting the medication in the morning slot since July 1. LPN-E stated, "I will not say yes, or no, this Saturday [the 20th of July 2024,] is when I set it up wrong for sure." The surveyor observed the morning pill slots for Sunday, and Monday was empty, and the pill slots for the rest of the week contained escitalopram 20 mg. The licensee's 7.08 Medication Management-Administration & Setup policy dated November 28, 2023, read: " POLICY: The nursing staff and unlicensed personnel trained to provide medication administration at Cosmo Home Healthcare Services will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *07/23/24*
Time: 11:14:16
Report: 1023241148

Food and Beverage Establishment Inspection Report

Location:
Vaimar Suites Llc
6050 68th Avenue North
Brooklyn Park, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0037935
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522217318
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND FIND AN APPLICATION HERE:
https://fmctraining.web.health.state.mn.us/search/index.cfm

Comply By: 07/23/24

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

INSTRUCTED STAFF TO REMOVE WOODEN CUTTING BOARD AND UTENSILS FROM THE FACILITY.

Comply By: 07/23/24

4-200 Equipment Design and Construction

4-202.16

MN Rule 4626.0540 Provide non-food contact surfaces that are free of unnecessary ledges, projections and crevices and are designed and constructed to allow easy cleaning.

OBSERVED GAP ALONG STOVE BETWEEN COUNTERTOPS. RECONFIGURE AREA TO BE FREE OF GAPS TO PREVENT FOOD DEBRIS ACCUMULATING BELOW.

Comply By: 07/23/24

Surface and Equipment Sanitizers

Chlorine: = at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Hot Water: = at 150 Degrees Fahrenheit
Location: ANSI 184 DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/JUICE
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND FIND AN APPLICATION HERE:
https://fmctraining.web.health.state.mn.us/search/index.cfm

Type: Full
Date: *07/23/24*
Time: 11:14:16
Report: 1023241148
Vaimar Suites 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 1023241148 of 07/23/24.

Certified Food Protection Manager: BOYD MUMBUWA

Certification Number: SERVSAF Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
BOYD MUMBUWA
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us