Electronically Delivered

November 29, 2022

Administrator
Divine Mercy Homes LLC
6325 Xerxes Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL37828015

Dear Administrator:

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.

The Minnesota Department of Health completed an initial evaluation on October 19, 2022, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 imposed immediately with no opportunity to correct the violation first as follows:

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

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

**DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91 Subd. 8), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

**REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Paul Spencer, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: paul.spencer@state.mn.us
Phone: 651-587-4460 | Fax: 651-215-6894

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37828 | A. BUILDING: _____ B. WING _____ | 10/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIVINE MERCY HOMES LLC | 6325 XERXES AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey<br><br>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.<br><br>INITIAL COMMENTS:<br>SL#37828015<br><br>On October 17, 2022, through October 19, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were two residents receiving services under the provider's Provisional Assisted Living Facility License. | 0 000 | | |
| 0 660 SS=D | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that | 0 660 | | |

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| 0 660 | Continued From page 1<br>covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and history and symptom screening for three of six unlicensed personnel (ULP-C, ULP-D, ULP-E) with employee records reviewed.<br><br>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).<br><br>The findings include:<br><br>ULP-C<br><br>ULP-C employee record showed a hire date of May 2, 2022.<br><br>ULP-C lacked a two-step Mantoux on hire or a negative IGRA laboratory blood test. ULP-C's most recent chest x-ray was dated May 2, 2019, | 0 660 | | |

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| 0 660 | Continued From page 2<br>which is not within 90 days of hire. No TB Baseline screening tool was completed at hire.<br><br>ULP-D<br><br>ULP-D's employee record showed a hire date of April 25, 2022.<br><br>ULP-D's record lacked a two-step Mantoux on hire or a negative IGRA laboratory blood test. ULP-D's most recent chest x-ray was dated February 7, 2017, which is not within 90 days of hire. A Baseline screening tool was completed but not dated when hired. The Baseline Screening tool indicated ULP-D previously tested positive for TB but not a date of that positive test.<br><br>ULP-E<br><br>ULP-E's employee record showed a hire date of April 12, 2022.<br><br>ULP-E's TB Baseline Screening Tool lacked a date the form was completed. ULP-E lacked a two-step Mantoux on hire or a negative IGRA laboratory blood test. ULP-E's most recent chest x-ray was dated March 9, 2018, and most recent TB Gold Test was completed on July 31, 2019, which is not within 90 days of hire.<br><br>During an interview on October 18, 2022, at 10:04 a.m., with licensed assisted living director (LALD)-A stated each new hire packet contains a copy of the Baseline Screen Tool for TB for employees to complete and indicated some were not dated or signed. LALD-A stated she was not aware of new hires requiring a two-step Mantoux or a blood test if they had proof of prior negative blood tests or chest x-rays. | 0 660 | | |

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| 0 660 | Continued From page 3<br><br>The licensee's TB Prevention and Control policy, not dated, indicated the facility will:<br>-upon hire screen all staff for active signs of TB using the Baseline TB Screening Tool;<br>-Upon hire all staff are tested for tuberculosis with either a two-step Mantoux or an IGRA laboratory blood test. If a staff presents a two-step Mantoux with negative results or a negative IGRA test within 90-days of hire, this will be used for proof of negative result and the staff member does not need further testing. A chest x-ray will be accepted if the staff member has a negative chest x-ray and the positive Mantoux test that required the chest x-ray, and the chest x-ray must be 90-days prior to or any time after the positive Mantoux test.<br>-no staff will be permitted to begin work where the work involved sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented; and<br>-staff TB screening results will be kept in each employee medical file.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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; | 0 680 | | |

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| 0 680 | Continued From page 4<br><br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop a written emergency disaster plan with all the required content, make annual training available to residents, and post an emergency disaster plan prominently. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On October 18, 2022, at 9:06 a.m., the surveyor | 0 680 | | |

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| 0 680 | Continued From page 5<br>reviewed the 9.01 Emergency Preparedness Plan, dated January 26, 2022. The same document did not include detail regarding what the licensee plan of action to facilitate the management of resident cares and services in response to a natural disaster or other emergencies which may disrupt the licensee's ability to provide care and/or services. The plan included a Home Care Emergency Preparedness Assessment and Assignment Sheet which was blank.<br><br>The licensee's plan lacked the following required content:<br>- a description of the facilities approach to meeting the health/safety/security needs of the staff and residents;<br>- process for EP cooperation with state and local EP officials/organizations.<br>- a thoroughly completed risk assessment;<br>- arrangements/contracts to re-establish utility services; and<br>- a description of the population served by the licensee.<br>- development of policies/procedures to address:<br>- procedure for tracking staff and residents;<br>- subsistence needs for staff and residents during an emergency;<br>- evacuation plan;<br>- shelter in place;<br>- a medical record documentation system to preserve resident information, security, and availability;<br>- emergency staffing strategies to include volunteers;<br>- development of arrangements with other facilities and providers to receive residents if needed; and<br>- the facilities role in providing care and treatment at alternative sites. | 0 680 | | |

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| 0 680 | Continued From page 6<br><br>- a communication plan that included:<br>- arrangement with other facilities;<br>- system to track the location of on-duty staff and sheltered residents<br>- names and contact information for staff, resident physicians, other facilities;<br>- contact information for federal, state, tribal, local EP staff, ombudsman;<br>- primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies;<br>- a method of sharing information and medical documentation for residents; and<br>- a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy.<br>- emergency preparedness training and documentation of training<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 680 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story | 0 780 | | |

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| 0 780 | Continued From page 7<br>within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the interconnection of the required smoke alarms and one nonworking smoke alarm in the hallway of the basement. This has the potential to directly affect occupied residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On October 17, 2022, approximately from Noon to 1:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. Survey staff observed the following finds:<br><br>1) The smoke alarm located in bedroom # 5 (basement) sounded local and the smoke alarm | 0 780 | | |

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| 0 780 | Continued From page 8<br>in the hallway outside of bedroom #5 failed to sound when tested by the LALD-A. Survey staff explained to LALD-A that the smoke alarms in the basement must be interconnected with the main level smoke alarms to sound throughout. LALD-A confirmed that these two smoke alarms were not interconnected with the smoke alarms on the main floor.<br><br>2) The smoke alarm located next to the bedroom with the high ceiling was incorrectly installed on the wall at approximately 24 inches below the ceiling.<br><br>On October 17, 2022, at approximately 1:45 p.m., at the exit interview, LALD-A acknowledged the findings.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 780 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and | 0 790 | | |

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| 0 790 | Continued From page 9<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff.<br><br>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).<br><br>The findings include:<br><br>On October 17, 2022, approximately from Noon to 1:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. Survey staff observed the installed portable fire extinguishers located on the main level floor and the basement were observed with no tags attached to indicate monthly inspections.<br><br>On October 17, 2022, at approximately 1:45 p.m., the LALD-A acknowledge the findings and stated that she understands the extinguishers needed to be inspected monthly at the exit interview.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days | 0 790 | | |

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| 0 800 | Continued From page 10 | 0 800 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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 all residents and staff.<br><br>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).<br><br>The findings are:<br><br>On October 17, 2022, approximately from Noon to 1:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. Survey staff observed the following findings during the tour:<br><br>The encasement cranked-type windows on the main floor for the two resident bedrooms did not | 0 800 | | |

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| 0 800 | Continued From page 11<br>meet the minimum clear width opening dimension of 20 inches when opened and measured due to the crank-type hardware having a hinge and elbow obstructing the width when opened. Survey staff measured the clear window opening dimensions of the unoccupied two rooms with a width of 16 inches and height of 44 inches for both windows. LALD-A stated that they will relocate the hardware elbow to provide for a minimum width opening of 20 inches.<br><br>On October 17, 2022, at approximately 1:45p.m., at the exit interview, LALD-A acknowledge the findings.<br><br>No further information was provided.<br><br>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<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation | 0 810 | | |

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| 0 810 | Continued From page 12<br>plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan and the minimum number of evacuation drills. This has the potential to directly affect the safety of occupied residents receiving care, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On October 17, at approximately 1:00 p.m., survey staff reviewed and interviewed licensed | 0 810 | | |

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| 0 810 | Continued From page 13<br>assisted living director (LALD)-A on the home's fire safety and evacuation documentation, the evacuation drill, and the training documentation. Document review and interview with LALD-A at approximately 1:30 p.m. indicated the following:<br><br>FIRE SAFETY AND EVACUATION PLAN<br>1) A discrepancy existed between the home floor layout plan of the bedroom locations and the numbering of the wireless nurse call system. The licensee is required to develop and maintain an accurate home floor plan as part of the fire safety and emergency evacuation plan. This was evident when LALD-A referred to the room numbers that did not match the floor layout.<br>2) The home's fire policy, dated January 26, 2022, lacked site-specific fire protection procedures for employees. The documentation had incorrect procedures in that the home was provided with a fire sprinkler system by indicating that sprinklers will be activated as necessary. In addition, the procedures also referred to magnetic holders for fire doors which the home did not have.<br><br>EVACUATION DRILLS<br><br>Document review indicated the licensee failed to provide the minimum required evacuation drills for compliance with two evacuation drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. The drill record review showed fire drills performed, but the records or indications relating to evacuation information. Survey staff explained that employee fire drills must also include evacuation drills. Fire safety and evacuation drills may be performed at the same time and be recorded as such. | 0 810 | | |

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| 0 810 | Continued From page 14<br><br>On October 17, 2022, at approximately 1:40 p.m., during the interview, LALD-A acknowledged the above findings.<br><br>Additional information was received via email on October 19, 2022, from LALD-A regarding resident movement and evacuation assistance during a fire or an emergency and employee fire safety training on June 4, 2022.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 900 SS=D | 144G.50 Subdivision 1 Contract required<br><br>(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.<br><br>(b) The contract must contain all the terms concerning the provision of:<br>(1) housing;<br>(2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and<br>(3) the resident's service plan, if applicable.<br><br>(c) A facility must:<br>(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and<br>(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. | 0 900 | | |

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| 0 900 | Continued From page 15<br>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.<br><br>(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.<br><br>(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written assisted living contract prior to providing assisted living services for one of one resident (R1) with records reviewed.<br><br>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).<br><br>The findings include:<br><br>R1's began receiving assisted living services on April 7, 2022.<br><br>R1's Service Plan initiated by the licensee on April 7, 2022, indicated R1 received services, which included assistance with dressing, feeding, | 0 900 | | |

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| 0 900 | Continued From page 16<br>hygiene and grooming, toileting, medication administration, assistance with ordered treatments, transfers and mobility, laundry, and housekeeping.<br><br>R1's Service Plan was initiated on the date of admission but lacked resident or designated signature until April 26, 2022.<br><br>During an interview on October 19, 2022, at 12:15 p.m., licensed assisted living director (LALD)-A stated R1's services started on April 7, 2022 and verified R1's Service Plan was not signed by the guardian until April 26, 2022.<br><br>No facility service plan policy was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 900 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 | 01620 | | |

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| 01620 | Continued From page 17<br>calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to properly assess the wheelchair lap belt used for one of one resident (R1) with record review.<br><br>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).<br><br>Finding include:<br><br>R1 admitted on April 7, 2022.<br><br>R1's service plan, dated April 7, 2022, indicated R1 received services for dressing, grooming, bathing, continence care, transfers, mobility, and medication administration and management.<br>R1's diagnoses include schizophrenia, epilepsy, and moderate cognitive impairment and impaired judgement.<br><br>During on observation on October 18, 2022, at 12:11 a.m., R1 located sitting in her wheelchair | 01620 | | |

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| 01620 | Continued From page 18<br>with a secured lap belt around her waist. The buckle of the belt was flipped inwards towards R1's abdomen.<br><br>During an interview on October 18, 2022, at 12:11 a.m., ULP-C stated R1 was able to release the belt and the reason the belt clasp is turned towards the R1's abdomen so she cannot release the belt herself.<br><br>During an interview on October 18, 2022, licensed assisted living director (LALD)-A stated R1 was unable to release the lap belt herself, but to be on the safe said the staff turned the buckle backwards to ensure R1 did not release the belt herself.<br><br>During an interview on October 18, 2022, at 1:26 p.m., LALD-A stated no lap belt assessment had been completed and there was no physician order for the lap belt. LALD-A stated R1 was admitted to the facility with a lap belt already in the wheelchair.<br><br>R1's fall risk assessment, dated October 1, 2022, indicated R1 action to reduce fall risk included a wheelchair seat belt.<br><br>R1's Individual Abuse Prevention Plan, dated September 18, 2022, indicated R1 requires two staff total assist with Hoyer lift device to transfer R1 from bed to wheelchair and wheelchair to bed. R1 is very weak to bear weight or walk and requires staff assist to push her wheelchair.<br><br>R1's Individualized Treatment and Therapy Plan dated October 2, 2022, lacked wheelchair seatbelt information which would include frequency of use, staff to perform and details, and who oversees supervision. R1 uses a wheelchair | 01620 | | |

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| 01620 | Continued From page 19<br>seat belt to address fall risk.<br><br>Master Care Plan dated September 18, 2022, indicated R1 tends to slide off the wheelchair and staff are to ensure seat belt is on whenever R1 is up in her wheelchair.<br><br>The licensee did not provide a policy related to assessments.<br><br>TIME PERIOD TO CORRECT: Twenty-one (21) Days | 01620 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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.<br>(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 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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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.<br>(e) Staff providing services must be informed of the current written service plan. | 01640 | | |

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| 01640 | Continued From page 20<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed execute a written assisted living contract prior to providing assisted living services and to ensure the service plan reflected the current services provided for one of one resident (R1) reviewed for service plans.<br><br>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).<br><br>Findings include:<br><br>R1 was admitted on April 7, 2022. R1's diagnoses included schizophrenia, epilepsy, and diabetes.<br><br>R1's service plan dated May 2, 2022, indicated R1 always requires two staff assistance with peri-care. R1 is consistently incontinent of bowel and bladder. R1 requires repositioning every 2 hours due to history of pressure ulcers.<br><br>Duing an observation on October 18, 2022, at 12:11 p.m. two staff required to transfer, change brief, boost up in bed, and position. R1 will stiffen up with cares and provide resistance.<br><br>During an interview on October 18, 2022, at 1:26 p.m., licensed assisted living director (LALD)-A stated one staff is scheduled on the overnight | 01640 | | |

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| 01640 | Continued From page 21<br>shift. LALD-A stated two staff are scheduled on both the day and afternoon schedule and cannot afford to pay for two overnight staff.<br><br>Review of the licensee's October 15, 2022, through October 28, 2022, work schedule indicated on the 11:00 p.m. to 7:00 a.m. shift only one staff is listed on the schedule for each night.<br><br>The licensee's 4.06 Staffing & Scheduling policy, dated January 25, 2022, indicated the clinical nurse supervisor must ensure that staffing levels are adequate to address each resident's needs, as identified in the resident's service plan and assisted living contract.<br><br>TIME PERIOD TO CORRECT: Twenty-One (21) days | 01640 | | |
| 02410 SS=D | 144G.91 Subd. 13 Personal and treatment privacy<br><br>(a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan.<br>(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. | 02410 | | |

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| 02410 | Continued From page 22<br>(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and record review, the licensee failed to ensure services were provided in a person-centered manner that promoted resident dignity and privacy for one of one resident (R1) reviewed.<br><br>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).<br><br>Findings include:<br><br>R1 was admitted on April 7, 2022.<br><br>R1's service plan, dated April 7, 2022, indicated R1 received services for housekeeping, laundry, eating assistance, dressing, grooming, bathing, continence care, transfers, mobility, and medication administration and management. R1's diagnoses include schizophrenia, epilepsy, and moderate cognitive impairment and impaired judgement.<br><br>During an observation on October 18, 2022, at | 02410 | | |

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|---|---|
| DIVINE MERCY HOMES LLC | 6325 XERXES AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
|---|---|---|---|---|
| 02410 | Continued From page 23<br><br>12:11 p.m., licensed assisted living director (LALD) and unlicensed personnel (ULP)-B proceeded to transfer R1 from her wheelchair to the bed, remove her clothing, and change her brief all with R1's bedroom door open.<br><br>The licensee's Minnesota Bill of Rights for Assisted Living Residents, not dated, indicated privacy must be respected during toileting, bathing, and other activities of personal hygiene.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 02410 | | |
| 03090 SS=C | 144.6502, Subd. 8 Notice to Visitors<br><br>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."<br><br>(b) The facility is responsible for installing and maintaining the signage required in this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff and any visitors of the facility.<br><br>This practice resulted in a level one violation (a violation that has not potential to cause more than | 03090 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37828 | A. BUILDING: _____ B. WING _____ | 10/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIVINE MERCY HOMES LLC | 6325 XERXES AVENUE NORTH BROOKLYN CENTER, MN 55430 |

| (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 |
|---|---|---|---|---|
| 03090 | Continued From page 24<br>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).<br><br>The finding include:<br><br>On October 17, 2022, at 9:15 a.m. upon arriving at the establishment, the survyeor observed the front entrance, and just inside the front entrance, lacked the required posting for electronic monitoring devices.<br><br>On October 18, 2022, at 8:50 a.m., licensed assisted living director (LALD)-A confirmed there was a camera located in the main entrance of the facility. LALD-A stated she was not aware of the required posting related to the statutory language for electronic monitoring.<br><br>The licensee's policy titled Electronic Monitoring, dated January 25, 2022, indicated signs are installed at each facility entrance accessible to visitors that state "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities."<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 03090 | | |

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *10/17/22*
Time: 15:50:10
Report: 7994221180

# Food and Beverage Establishment Inspection Report



**Location:**
Divine Mercy Homes LLC
6325 Xerxes Ave North
Brooklyn Center, MN55430
Hennepin County, 27

**Establishment Info:**
ID #: 0040868
Risk:
Announced Inspection: No

**License Categories:**

Expires on: 12/31/22

**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.

**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.

WRONG TYPE OF TEST KIT FOR CHLORINE SANITIZER WAS FOUND ON SITE. GAVE OWNER INFORMATION ON PROPER TEST STRIPS.

*Comply By: 10/21/22*

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

**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 7994221180 of 10/17/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994221180

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

**Minnesota Department of Health**
**625 Robert Street North**
**St Paul**

| | | | |
|---|---|---|---|
| **No. of RF/PHI Categories Out** | 0 | **Date** | 10/17/22 |
| **No. of Repeat RF/PHI Categories Out** | 0 | **Time In** | 15:50:10 |
| **Legal Authority MN Rules Chapter 4626** | | **Time Out** | |

| Establishment | Address | City/State | Zip Code | Telephone |
|---|---|---|---|---|
| Divine Mercy Homes LLC | 6325 Xerxes Ave North | Brooklyn Center, MN | 55430 | |

| License/Permit # | Permit Holder | Purpose of Inspection | Est Type | Risk Category |
|---|---|---|---|---|
| 0040868 | | Full | | |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

**IN=** in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

| Compliance Status | | | COS | R |
|---|---|---|---|---|
| **Supervision** | | | | |
| 1 | IN OUT | PIC knowledgeable; duties & oversight | | |
| 2 | IN OUT N/A | Certified food protection manager, duties | | |
| **Employee Health** | | | | |
| 3 | IN OUT | Mgmt/Staff;knowledge,responsibilities&reporting | | |
| 4 | IN OUT | Proper use of reporting, restriction & exclusion | | |
| 5 | IN OUT | Procedures for responding to vomiting & diarrheal events | | |
| **Good Hygenic Practices** | | | | |
| 6 | IN OUT N/O | Proper eating, tasting, drinking, or tobacco use | | |
| 7 | IN OUT N/O | No discharge from eyes, nose, & mouth | | |
| **Preventing Contamination by Hands** | | | | |
| 8 | IN OUT N/O | Hands clean & properly washed | | |
| 9 | IN OUT N/A N/O | No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed | | |
| 10 | IN OUT | Adequate handwashing sinks supplied/accessible | | |
| **Approved Source** | | | | |
| 11 | IN OUT | Food obtained from approved source | | |
| 12 | IN OUT N/A N/O | Food received at proper temperature | | |
| 13 | IN OUT | Food in good condition, safe, & unadulterated | | |
| 14 | IN OUT N/A N/O | Required records available; shellstock tags, parasite destruction | | |
| **Protection from Contamination** | | | | |
| 15 | IN OUT N/A N/O | Food separated and protected | | |
| 16 | IN OUT N/A | Food contact surfaces: cleaned & sanitized | | |
| 17 | IN OUT | Proper disposition of returned, previously served, reconditioned, & unsafe food | | |

| Compliance Status | | | COS | R |
|---|---|---|---|---|
| **Time/Temperature Control for Safety** | | | | |
| 18 | IN OUT N/A N/O | Proper cooking time & temperature | | |
| 19 | IN OUT N/A N/O | Proper reheating procedures for hot holding | | |
| 20 | IN OUT N/A N/O | Proper cooling time & temperature | | |
| 21 | IN OUT N/A N/O | Proper hot holding temperatures | | |
| 22 | IN OUT N/A | Proper cold holding temperatures | | |
| 23 | IN OUT N/A N/O | Proper date marking & disposition | | |
| 24 | IN OUT N/A N/O | Time as a public health control: procedures & records | | |
| **Consumer Advisory** | | | | |
| 25 | IN OUT N/A | Consumer advisory provided for raw/undercooked food | | |
| **Highly Susceptible Populations** | | | | |
| 26 | IN OUT N/A | Pasteurized foods used; prohibited foods not offered | | |
| **Food and Color Additives and Toxic Substances** | | | | |
| 27 | IN OUT N/A | Food additives: approved & properly used | | |
| 28 | IN OUT | Toxic substances properly identified, stored, & used | | |
| **Conformance with Approved Procedures** | | | | |
| 29 | IN OUT N/A | Compliance with variance/specialized process/HACCP | | |

**Risk factors** (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

## GOOD RETAIL PRACTICES

**Good Retail Practices** are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

| | | | COS | R |
|---|---|---|---|---|
| **Safe Food and Water** | | | | |
| 30 | IN OUT N/A | Pasteurized eggs used where required | | |
| 31 | | Water & ice obtained from an approved source | | |
| 32 | IN OUT N/A | Variance obtained for specialized processing methods | | |
| **Food Temperature Control** | | | | |
| 33 | | Proper cooling methods used; adequate equipment for temperature control | | |
| 34 | IN OUT N/A N/O | Plant food properly cooked for hot holding | | |
| 35 | IN OUT N/A N/O | Approved thawing methods used | | |
| 36 | | Thermometers provided & accurate | | |
| **Food Identification** | | | | |
| 37 | | Food properly labled; original container | | |
| **Prevention of Food Contamination** | | | | |
| 38 | | Insects, rodents, & animals not present | | |
| 39 | | Contamination prevented during food prep, storage & display | | |
| 40 | | Personal cleanliness | | |
| 41 | | Wiping cloths: properly used & stored | | |
| 42 | | Washing fruits & vegetables | | |

| | | | COS | R |
|---|---|---|---|---|
| **Proper Use of Utensils** | | | | |
| 43 | | In-use utensils: properly stored | | |
| 44 | | Utensils, equipment & linens: properly stored, dried, & handled | | |
| 45 | | Single-use/single service articles: properly stored & used | | |
| 46 | | Gloves used properly | | |
| **Utensil Equipment and Vending** | | | | |
| 47 | | Food & non-food contact surfaces cleanable, properly designed, constructed, & used | | |
| 48 | X | Warewashing facilities: installed, maintained, & used; test strips | | |
| 49 | | Non-food contact surfaces clean | | |
| **Physical Facilities** | | | | |
| 50 | | Hot & cold water available; adequate pressure | | |
| 51 | | Plumbing installed; proper backflow devices | | |
| 52 | | Sewage & waste water properly disposed | | |
| 53 | | Toilet facilities: properly constructed, supplied, & cleaned | | |
| 54 | | Garbage & refuse properly disposed; facilities maintained | | |
| 55 | | Physical facilities installed, maintained, & clean | | |
| 56 | | Adequate ventilation & lighting; designated areas used | | |
| 57 | | Compliance with MCIAA | | |
| 58 | | Compliance with licensing & plan review | | |

**Food Recalls:**

**Person in Charge (Signature)** **Date:** 11/02/22

Inspector (Signature) Crystal Elva