Electronically Delivered

September 19, 2024

Licensee
Welcome Homes Best Care
240 Hurley Street East
West Saint Paul, MN 55118

RE: Project Number(s) SL35899015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35899	A. BUILDING: _____ B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELCOME HOMES BEST CARE	240 HURLEY STREET EAST WEST SAINT PAUL, MN 55118

(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: SL# 35899015-0 On August 19, 2024, through August 20, 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; three receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 August 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 2 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 3 The licensee's Emergency Preparedness Manual last reviewed February 1, 2024, lacked the following required content: - Emergency prep testing requirements On August 19, 2024, at 3:45 p.m. licensed assisted living director (LALD)-A stated they had not been conducting full-scale exercises, mock disaster drills or tabletop exercises other than for fire safety, and was unaware of the requirement. The licensee's Emergency Preparedness Manual last reviewed February 1, 2024, indicated: Two (2) exercises are conducted at least annually to test the emergency plan, including unannounced staff drills using emergency procedures. The facility will participate in one full-scale exercise that is either community based with participating state and local agencies and some regional entities such as health care coalitions, or, if a community-based exercise is not accessible, an individual, facility based. A full-scale exercise does not require physically moving residents; the facility can perform a simulated full-scale exercise. If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for one year following the onset of the actual event. The facility will conduct an additional exercise that may include a table-top exercise that uses clinically relevant emergency scenarios to challenge an emergency plan. The facility will analyze its response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's facility emergency plan as needed.	0 680		

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0 680	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the	0 780		

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0 780	Continued From page 5 potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, at 11:00 a.m., survey staff toured the facility with owner (O)-E. During the tour, O-E tested smoke alarms installed in the facility. The surveyor observed when the smoke alarm installed in bedroom 4 was tested, it did not actuate the smoke alarm installed outside of this sleeping area. The smoke alarm installed outside bedroom 4 was not interconnected with the other smoke alarms in the dwelling unit. During the facility tour interview on August 20, 2024, O-E verified the dwelling unit smoke alarms were not interconnected as required by statute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	0 790		

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0 790	Continued From page 6 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 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 August 20, 2024, at 11:00 a.m., survey staff toured the facility with owner (O)-E. During the tour, the surveyor observed the following: 1. Tags or labels were not attached to the portable fire extinguishers showing annual maintenance had been performed by certified service personnel. 2. One monthly inspection was recorded for 2024 on the back of the tags attached to the portable fire extinguishers installed in the basement office and kitchen. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has	0 790		

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0 790	Continued From page 7 not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. 3. Portable fire extinguishers were not properly installed in the following locations: a. The fire extinguisher in the basement office was stored on the floor. b. The kitchen fire extinguisher was stored in a cabinet under the sink and not mounted. Fire extinguishers must be properly installed to prevent them from being moved or damaged. Extinguishers must be mounted at least 4 inches off the ground up to a maximum of 5 feet (the top of the fire extinguisher to be no more than 5 feet above the ground). Fire extinguishers need to be located along normal paths of travel, installed in visible locations, and readily available in an emergency. 4. Two fire extinguishers were stored on the floor in the laundry room. During the facility tour interview, O-E stated these were extra fire extinguishers. If fire extinguishers are located in a laundry room, they must be properly installed and maintained. During the facility tour interview on August 20, 2024, O-E verified the fire extinguishers were not properly installed and maintained. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the	0 800		

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0 800	Continued From page 8 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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, 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). The findings include: On August 20, 2024, at 11:00 a.m., survey staff toured the facility with owner (O)-E. During the tour, the surveyor observed the following: 1. The cover obstructed the egress window well for resident occupied bedroom 4. Egress window wells must be maintained to allow the occupant to safely exit the building in the event of an emergency. When covers are installed on egress window wells, the coverings must comply with the following requirements: a. The cover must not obstruct the window well opening or interfere with the opening of the egress window in any way. b. The cover must be designed so it cannot freeze to the ground, window well, or structure.	0 800		

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0 800	Continued From page 9 c. The cover must be removable without the use of tools or special knowledge. 2. The headboard obstructed the egress window in resident occupied bedroom 3. The improper placement of furniture could delay exiting in the event of an emergency. 3. The designated smoking area for residents was on the wooden deck at the front of the home. The disposal container for smoking materials was stored on top of a plastic bucket. There were ashes from smoking materials on the plastic lid for the bucket. Improper disposal of smoking materials creates a fire hazard. During the facility tour interview on August 20, 2024, O-E verified the inappropriate disposal of smoking materials and removed the plastic bucket from the deck. 4. Extension cords were used for televisions in the living room and unoccupied bedroom 2, creating a fire hazard. 5. The closet was off the track in resident occupied bedroom 3. 6. The cover for the light fixture was missing and the carpet soiled in resident occupied bedroom 4. During the facility tour interview on August 20, 2024, O-E, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 10 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 11 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, the owner (O)-E and licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the FSEP included a fire safety policy dated August 28, 2023. This policy was a template from a third-party provider and had not been developed for use at this facility. The FSEP fire safety policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE acronym (Rescue, Alarm, Contain, Extinguish/Evacuate). The FSEP fire safety policy failed to include specific fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency. The schematic plan for each floor level was blank in the evacuation plan section of the binder. The emergency floor plans posted in the facility did	0 810		

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0 810	Continued From page 12 not match. One version of the floor plan for emergency evacuation did not identify the location and number of resident sleeping rooms. The posted Welcome Homes Best Care LLC emergency floor plan did not include the numbers posted at the resident sleeping room doors. The numbers posted at resident sleeping room doors must be included on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. During an interview on August 20, 2024, at 12:00 p.m., LALD-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire evident by the lack of training documentation. No FSEP training records were provided for new hire employees. During an interview on August 20, 2024, at 12:00 p.m., LALD-A stated new employees completed emergency preparedness training using a third party online course provider. LALD-A verified this online training was not specific to the facility FSEP. Record review of the available documentation indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. No resident training records were provided for review. During an interview on August 20, 2024, at 12:00 p.m., LALD-A verified records to support resident training on fire safety and evacuation had been completed at least once per year were not available. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35899	A. BUILDING: _____ B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELCOME HOMES BEST CARE	240 HURLEY STREET EAST WEST SAINT PAUL, MN 55118

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0 810	Continued From page 13 year, per shift with at least one evacuation drill every other month evident by fire drill reports lacking the required frequency and documentation. One fire drill was conducted in 2024. Three fire drills were conducted in 2023. The time or shift of these drills was not recorded. During an interview on August 20, 2024, at 12:00 p.m., LALD-A verified the evacuation drill frequency was not met and the fire drill records lacked the required detail. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

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01500	Continued From page 14 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (house manager (HM)-B).	01500		

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	35899	A. BUILDING: _____ B. WING _____	08/20/2024

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01500	Continued From page 15 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: HM-B began providing direct care services, on August 1, 2021, under the licensee's assisted living license. On August 20, 2024, at 8:02 a.m. HM-B was observed administering medications to R1. HM-B's employee record lacked evidence the employee had successfully completed annual training to include the following: -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On August 20, 2024, at 9:40 a.m. licensed assistant living director (LALD)-A reviewed HM-B's employee file and was unable to locate evidence of the above training. The licensee's Staff Orientation and Education policy dated August 28, 2023, indicated: 12. All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 13. Education topics will include, but not be limited to, the following	01500		

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01500	Continued From page 16 c. Review of the organization's policies and procedures related to provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530		

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01530	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received the required amount of dementia care training. 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: ULP-D had a hire date of February 12, 2024. ULP-D's record included seven hours of training for dementia topics, but lacked an additional one hour of training to meet the required eight hours within 160 working hours of employment start date. On August 20, 2024, at 9:40 a.m. licensed assisted living director (LALD)-A reviewed ULP-D's training transcript and stated ULP-D had only completed seven hours of dementia training within the required 160 hour timeframe. The licensee's Dementia Education policy dated August 28, 2023, indicated: 3. Direct care employees must have completed at least eight (8) hours of initial education within 160 working hours of the employment start date in the following topics: a. An explanation of Alzheimer's Disease	01530		

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01530	Continued From page 18 and other dementias b. Assistance with activities of daily living (ADL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *08/21/24*
Time: 09:30:00
Report: 1031241229

Food and Beverage Establishment Inspection Report

Location:
Welcome Homes Best Care
240 Hurley Street East
West St Paul, MN55118
Dakota County, 19

Establishment Info:
ID #: 0038023
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514609188
ID #:

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

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

SANITIZER SPRAY MEASURED 100PPM. STAFF TO REMAKE SPRAY. USE TEST STRIPS TO CHECK CONCENTRATION DAILY.

Comply By: 08/21/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

LOWER SHELF BOTTOM TO LEFT OF OVEN IS DAMAGED. REPLACE SHELF BOTTOM.

Comply By: 09/10/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 100 at Degrees Fahrenheit
Location: Sani Spray Bottle
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Lettuce
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Type: Full
Date: *08/21/24*
Time: 09:30:00
Report: 1031241229
Welcome Homes Best Care

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/Deli Turkey
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

Nurse Evaluator on site: Wendy Buckholz

All violations discussed with Ahim during the inspection.

NOTES:
- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Staff must preparing a sanitizer quat squirt bottle daily. Check concentration with test strips (150-400ppn) daily.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Employee food needs to be labeled and separated from residents food.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

Type: Full
Date: *08/21/24*
Time: 09:30:00
Report: 1031241229
Welcome Homes Best Care

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 Environmental Health inspection report number 1031241229 of 08/21/24.

Certified Food Protection Manager: Samriya Abbadulla

Certification Number: FM121654 Expires: 01/21/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ahim Butta
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us