Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 10, 2023

Licensee
Care Partners Homecare LLC
7517 Edgewood Avenue North
Brooklyn Center, MN 55443

RE: Project Number(s) SL39367015

Dear Licensee:

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 survey on September 13, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state 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 . . ."

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

Per 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 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 correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

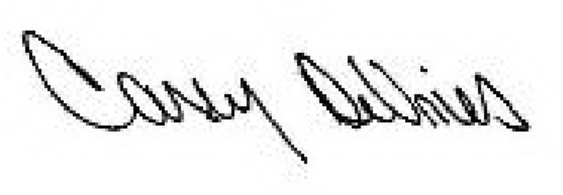
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39367	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	7517 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******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: SL39367015-0 On September 11, 2023, through September 13, 2023, 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, there were three residents; all of whom received services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director/ registered nurse (LALD/RN)-A was listed as the Director of Record for the licensee with the Board of Executives for Long-Term Services and Support (BELTSS). This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Registered nurse (RN)-A obtained an assisted living director license on September 9, 2021. On September 11, 2023, at 8:15 a.m., the surveyor reviewed the BELTSS website which indicated LALD/RN-A held a current assisted living director license, however, was not listed as the Director of Record for the provisional licensee. On September 11, 2023, at 11:45 a.m., LALD/RN-A identified themselves as the LALD for the provisional licensee. LALD/RN-A stated that they had overlooked putting themselves in as	0 110		

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0 110	Continued From page 2 Director of Record but would do so before completion of the survey process. On September 14, 2023, at 2:05 p.m., the surveyor reviewed the BELTSS website which indicated that LALD/RN- had not identified themselves as Director of Record for the provisional licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights (BOR) for assisted living to two of two residents (R1, R2). This practice resulted in a level one violation (a	0 450		

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0 450	Continued From page 3 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 R1 admitted to the licensee June 5, 2023, and began receiving assisted living services. Prior to admission R1 resided at a sister facility of the licensee (Health Facility Identification Number (HFID)). R2 R2 admitted to the licensee June 5, 2023, and began receiving assisted living services. Prior to admission R1 resided at a sister facility of the licensee (different HFID). R1 and R2's record included the assisted living BOR issued by the licensee's sister facility (different HFID). R1 and R2's record lacked evidence R1 and R2 received the assisted living BOR provided by the licensee. On September 11, 2023, at 2:21 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R1 and R2 transferred from a sister facility of the licensee and the licensee did not provide the BOR to the residents upon admission. LALD/RN-A stated they treated both facilities like they were the "same" and did not think about the change in HFID numbers. The licensee's 2.05 Bill of Rights policy dated August 1, 2021, indicated the licensee would	0 450		

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0 450	Continued From page 4 provide each resident with the assisted living BOR and acknowledgement of BOR receipt would be retained in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment	0 480		

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0 480	Continued From page 5 Inspection Reports, dated September 11, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of one unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	0 510		

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0 510	Continued From page 6 situation has occurred only occasionally). The findings include: On September 12, 2023, at 8:30 a.m., the surveyor observed ULP-B assist R2 into their bathroom. Without completing hand hygiene, ULP-B put on a single glove and assisted R2 onto the toilet and assisted in the removal of undergarments. After assisting R2 off the toilet, ULP-B removed the dirty glove and escorted R2 out of the rest room. The surveyor did not observe ULP-B complete hand hygiene or assist R2 with hand hygiene. On September 12, 2023, at 8:43 a.m., ULP-B stated that they were trained by assisted living director/registered nurse (LALD/RN)-A on infection control when they were hired. On September 12, 2023, at 9:31am, LALD/RN-A stated that infection control is included with new employee orientation via EduCare (a training software) modules as well as annual trainings. LALD/RN-A stated that staff are expected to adhere to proper handwashing procedures. The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated that proper handwashing techniques should used [sic] to protect the spread of infection. Hand washing shall be completed: - Before, during and after preparing food; - Before eating food; - Before and after caring for someone who is sick; - Before and after caring for someone who is sick; - Before and after treating a cut or wound; - After using the toilet; - After changing diapers or cleaning up after someone who has used the toilet;	0 510		

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0 510	Continued From page 7 - After blowing your nose, coughing, or sneezing; - After touching an animal or animal waste; - After handling per food or pet treats; - After touching garbage. In addition, the policy indicated, "When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	0 680		

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0 680	Continued From page 8 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - Hazards and Risk assessments; - Quarterly review of missing resident policy; - Policies and procedures for maintaining independence, communication, transportation, supervision and medical care; - Identification of which staff would assume specific roles in another's absence through succession planning and delegation of authority; - Policies and procedures for subsistence needs for staff and residents; - Policies and procedures for sheltering in place; - Roles under wavier declared by secretary;	0 680		

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0 680	Continued From page 9 - Development of Communication Plan; - Names and Contact Information including: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - Emergency officials contact information; - Primary/Alternate Means for Communication; - Methods for sharing information; and - Sharing information on Occupancy/Needs. On September 12, 2023, at 9:08 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated that they were under the impressions that due to the smaller size of their facility, there would be less requirements for the facilities emergency preparedness plan (EPP). Details were not given to specify what information would not need to be included into EPP. LALD/RN-A stated that there was no additional information to add. 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;	0 780		

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0 780	Continued From page 10 (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 a working and an interconnected hallway smoke alarm within the vicinity of the main-level resident bedrooms as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to prevent the early notification of smoke and/or fire for the residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 11, 2023, between 1:40 p.m. to 2:20 p.m. survey staff toured with the unlicensed personnel-B, and between 2:30 p.m. to 2:50 p.m., survey staff toured with the licensed assisted	0 780		

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0 780	Continued From page 11 living director / registered nurse (LALD/RN)-A. During the home tour with the LALD/RN-A, the LALD/RN-A tested the hallway smoke alarm outside the main-level resident bedrooms of the home, and the hallway alarm failed to sound for proper notifications. The finding was verbally verified by the LALD/RN-A as he attempted to repair the smoke alarm to sound but it then failed to interconnect by activating the other smoke alarms in the home. On September 11, 2023, at approximately 3:00 p.m., the LALD/RN-A acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=B	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 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, record review, and	0 790		

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	39367	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	7517 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 12 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. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: On September 11, 2023, between 1:40 p.m. to 2:20 p.m. survey staff toured with the unlicensed personnel-B, and between 2:30 p.m. to 2:50 p.m., survey staff toured with the licensed assisted living director/registered nurse (LALD/RN)-A. During the home tour with the LALD/RN-A, survey staff located two mounted portable fire extinguishers, one installed on the main floor and one in the basement, and observed that both portable fire extinguishers lacked records to show the required monthly inspections to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. The LALD/RN-A verbally verified the findings during the home tour. On September 11, 2023, at approximately 3:00 p.m., the LALD/RN-A acknowledged the findings. No further information was provided.	0 790		

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0 790	Continued From page 13 TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide an accurate and complete content of the fire safety and evacuation plan. This has the potential to directly affect the safety of all residents receiving care, 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 September 11, 2023, between 1:40 p.m. to 2:20 p.m. survey staff toured with the unlicensed personnel (ULP)-B, and between 2:30 p.m. to 2:50 p.m., survey staff toured with the licensed assisted living director/registered nurse (LALD/RN)-A. On September 11, 2023, at approximately 2:50 p.m., survey staff received and reviewed the home's fire safety and evacuation, the evacuation drill, and the training documentation. At approximately, 3:00 p.m., document review and interview with the licensed LALD/RN-A, indicated the following: -Document review indicated that the home's fire policy lacked fire protection procedures for residents.	0 810		

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0 810	Continued From page 15 -The posted basement floor plan incorrectly showed two bedrooms (#6 and #7) that do not exist. Survey staff asked the LALD/RN-A about the bedrooms shown on the plan posted on the wall and the LALD/RN-A agreed there are no bedrooms in the basement and he will post a new basement floor plan to accurately reflect the conference room and the staff/medication room, rather than the bedrooms. On September 11, 2023, at approximately 3:00 p.m., the LALD/RN-A confirmed and acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting	0 900		

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0 900	Continued From page 16 documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee had a provisional assisted living license issued on November 4, 2022. R1 R1 admitted to the licensee on June 5, 2023, and	0 900		

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0 900	Continued From page 17 began receiving assisted living services. Prior to admission R1 resided at a sister facility of the licensee (different Health Facility Identification Number (HFID)). On September 12, 2023, at 8:00 a.m., the surveyor observed unlicensed personnel administer oral medication to R1. R1's record included an Assisted Living Residency Agreement / Contract signed December 12, 2021, provided to R1 by the sister facility of the licensee. R1's record lacked a written contract with the required content provided by licensee. R2 R2 admitted to the licensee on June 5, 2023, and began receiving assisted living services. Prior to admission R2 resided at a sister facility of the licensee (different HFID). On September 12, 2023, at 8:03 a.m., the surveyor observed ULP-B administer oral medications to R2. R2's record included an Assisted Living Residency Agreement / Contract signed September 8, 2021, provided to R2 by the sister facility of the licensee. R2's record lacked a written contract with the required content provided by licensee. On September 11, 2023, licensed assisted living director/registered nurse (LALD/RN)-A stated R1 and R2 transferred from a sister facility and the licensee did not provide a contract upon admission to the residents. LALD/RN-A stated they treated both facilities like they were the "same" and did not think about the change in	0 900		

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0 900	Continued From page 18 HFID numbers. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, read, "When a prospective resident decides to move into Care Partners Homecare LLC a signed Assisted Living contract signed and received by the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover	0 940		

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0 940	Continued From page 19 the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 11, 2023, at 1:18 p.m., licensed assisted living director/registered nurse (LALD/RN)-A provided the surveyor with a blank Assisted Living Residency Agreement / Contract and indicated the document was used by licensee for all residents who received services. The Residency Agreement lacked the licensee's information on the following content:	0 940		

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0 940	Continued From page 20 - a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - when there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time the limit must be provided; On September 13, 2023, at 8:55 a.m., LALD/RN-A stated there were unaware the limit needed to be provided if they limited the number of people in the facility who could receive customized living or participate in the housing support program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	01060		

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01060	Continued From page 21 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative, for one of one resident (R1) hospitalized. 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	01060		

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01060	Continued From page 22 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to licensee on June 5, 2023, and began receiving assisted living services. R1's Progress notes dated August 27, 2023, through August 30, 2023, indicated R1 was transferred by emergency medical services on August 27, 2023, to the hospital for a change in respiratory status. R1 returned to the facility on August 30, 2023, and resumed assisted living services. R1's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. On September 12, 2023, at 10:03, 2023, at 11:15 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they were unfamiliar of the emergency relocation notice requirement, and they had not provided a notice to anyone hospitalized. In addition, LALD/RN-A stated, "I am going to be honest, I forgot." The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, read, "In the event of an emergency relocation, Care Partners Homecare LLC will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated	01060		

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01060	Continued From page 23 and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01530 SS=F	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	01530		

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01530	Continued From page 24 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure supervisors of direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of two employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: CNS-C began employment under the umbrella of the parent company and worked at a sister facility of the licensee (different HFID) on September 16, 2018, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C began providing services for licensee on May 15, 2023. CNS-C's employee record included seven hours of dementia care training completed August 21, 2021, through August 22, 2021, however the	01530		

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01530	Continued From page 25 training was completed 20 months prior to employment for licensee and lacked the required topic of assistance with activities of daily living. CNS-C's employee record lacked eight hours of initial dementia care training. On September 12, 2023, at 9:17 a.m., the surveyor inquired how many initial hours of dementia training each employee received. Licensed assisted living director/registered nurse (LALD/RN)-A looked up the dementia care policy and stated each employee should receive eight hours. LALD/RN-A stated they trained employees either in person or via computer with the courses provided by EduCare (a training software). LALD/RN-A stated they accidently did not assign one of the required classes in EduCare. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated supervisors of direct care staff would complete eight hours of initial training within 120 hours of the employment start date. In addition, if an employee had written proof of completing the required training within the past 18 months this would satisfy the initial training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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	39367	A. BUILDING: _____ B. WING _____	09/13/2023

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01620	Continued From page 26 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a 14-day assessment no more than 14 calendar days after initiation of services for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01620		

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01620	Continued From page 27 The findings include: R1 R1 admitted to the licensee on June 5, 2023, and began receiving assisted living services. Prior to admission R1 resided at a sister facility of the licensee (different Health Facility Identification Number (HFID)). R1's diagnoses included major depression, cerebral infarction (stroke), diabetes mellitus type 2 (DM2), muscle weakness, congestive heart failure, encephalopathy, obstructive sleep apnea, cannabis use, anxiety disorder, hypertension, atrial fibrillation (A-Fib), and chronic kidney disease stage 3. R1's record lacked a current service plan provided by the licensee however, included a Service Plan dated December 22, 2023 [sic], provided by the licensee's sister facility (different HFID). R1's Service Plan indicated R1 received assistance with medication administration, medication set up, transfers, bathing, grooming, dressing, toileting, safety checks, laundry, activities, housekeeping, meals, transportation, continuous positive airway pressure (CPAP) management, and behavior management. On September 12, 2023, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medication to R1. R1's record included an assessment dated March 21, 2023, completed prior to R1's admission to the licensee, and 14-day nursing assessment dated July 3, 2023, which indicated 28 days passed since R1's admission.	01620		

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01620	Continued From page 28 R2 R2 was admitted to the licensee on June 5, 2023, and began receiving assisted living services. Prior to admission R2 resided at a sister facility of the licensee (different HFID). R2's diagnoses includes traumatic brain injury (TBI), depression, anxiety, and bipolar disorder. On September 13, 2023, at 7:59 a.m., the surveyor observed ULP-B administer oral medication to R2. R2's record lacked a current service plan provided by the licensee however, included a Service Plan dated September 1, 2022, provided by the licensee's sister facility (different HFID). R2's Service Plan indicated R2 received assistance with medication administration, medication set up, transfers, bathing, grooming, dressing, toileting, safety checks, laundry, activities, housekeeping, meals, and transportation. R2's record included an assessment completed on April 18, 2023, prior to R2's admission to the licensee, and an assessment dated July 12, 2023, which indicated 37 days passed since R1's admission. On September 12, 2023, at 9:57 a.m., LALD/RN-A stated the licensee was in a transition period with nurses and the assessment was not "flagged" to be completed. In addition, LALD/RN-A stated they noticed the error and immediately set up the assessment and then completed the assessment for R1. In addition, LALD/RN-A stated they continued the same assessment schedule after the residents transitioned from a sister facility (different HFID).	01620		

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01620	Continued From page 29 The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated the licensee would conduct a nursing assessment by a RN of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which the prospective resident executes a contract with a facilty or the date on which a prospective resident moves in, whichever is earlier. In addition, resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640		

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01640	Continued From page 30 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was provided no later than 14 calendar days after the date that services were first provided for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 admitted to the licensee on June 5, 2023, and began receiving assisted living services. Prior to admission R1 resided at a sister facility of the licensee (different health facility identification number (HFID)). R1's diagnoses included major depression, cerebral infarction (stroke), diabetes mellitus type 2 (DM2), muscle weakness, congestive heart failure, encephalopathy, obstructive sleep apnea, cannabis use, anxiety disorder, hypertension, atrial fibrillation (A-Fib), and chronic kidney	01640		

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01640	Continued From page 31 disease stage 3. On September 12, 2023, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medication to R1. R1's Service Plan dated December 22, 2023 [sic], completed by the sister facility, indicated R1 received assistance with medication administration, medication set up, transfers, bathing, grooming, dressing, toileting, safety checks, laundry, activities, housekeeping, meals, transportation, continuous positive airway pressure (CPAP) management, and behavior management. R1's record lacked a current service plan provided by the licensee. R2 R2 was admitted to the licensee on June 5, 2023, and began receiving assisted living services. Prior to admission R2 resided at a sister facility of the licensee (different HFID). R2's diagnoses includes traumatic brain injury (TBI), depression, anxiety, and bipolar disorder. On September 13, 2023, at 7:59 a.m., the surveyor observed ULP-B administer oral medication to R2. R2's Service Plan dated September 1, 2022, completed by the sister facility, indicated R2 received assistance with medication administration, medication set up, transfers, bathing, grooming, dressing, toileting, safety checks, laundry, activities, housekeeping, meals, transportation. R2's record lacked a current service plan provided by the licensee. On September 14, 2023, at 12:40 p.m., licensed	01640		

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01640	Continued From page 32 assisted living director/registered nurse (LALD/RN)-A stated the licensee normally visits potential residents in the hospital to create a temporary service plan, and upon admission or prior to day 14, the licensee reviews the service plan with resident and obtains a signature for agreed upon services. In addition, LALD/RN-A stated nothing changed from the resident's service plans from facility to facility however, they treated both facilities as one and they did not think about the change in HFID numbers. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated within 14 days after the date that services are first provided to a resident, the licensee would finalize a written service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 33 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider orders for one of three residents (R3). In addition, the licensee failed to ensure unlicensed personnel ((ULP)-B) followed appropriate medication administration procedures for three of three residents (R3, R2, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ADMINISTERED PER PROVIDER ORDERS R3 was admitted to the licensee on May 15, 2023, and began receiving assisted living services. R3's signed Service Plan dated, May 28, 2023, indicated R3 received assistance with medication administration, medication management, assistance with bathing, and housekeeping tasks. R3's electronic medication administration record indicated R3 was to be administered Dulera 200mcg-5mcg inhaler twice daily at 9:00 a.m., and 9:00 p.m., and fluticasone propionate 50mcg/act suspension once daily 9:00 a.m. On September 13, 2023, from 7:42 a.m. to 7:56	01760		

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01760	Continued From page 34 a.m., the surveyor observed ULP-B administer benztropine 10mg, certavite 18-400mg-mcg, one half tab of chlorthalidone 25mg, docusate sodium 100mg, glipizide 2.5mg, metformin 1000mg, omeprazole 20mg, 2 tablets of senna time 8.6mg, vitamin D3 25mcg, Rybelsus 3mg. The surveyor did not observe the administration of Dulera 200mcg-5mcg inhaler or fluticasone propionate 50mcg/act suspension. ULP-B was observed dumping medications from bubble packs into a medication cup, and then handed the medication cup to R3 for self-administration. R3 was then observed consuming the medications provided to them by ULP-B. ULP-B retrieved the laptop to document medications as being administered. On September 13, 2023, at 9:22 a.m., ULP-B stated that they did not administer either of those medications (Dulera 200mcg-5mcg inhaler or fluticasone propionate 50mcg/act suspension) as they were scheduled to be given at bedtime. ULP-B was unaware that they had signed off the medications were given but not administered. R3's medication administration record indicated that during the month of September 2023, ULP-B documented administering Dulera 200mcg-5mcg inhaler and fluticasone propionate 50mcg/act suspension at 9:00 a.m., on September 1, September 4, September 5, September 6, September 8, September 10, September 11, and September 12, in addition to the surveyors observation on September 13, 2023. PROCEDURE ULP-B started employment with licensee May 11, 2023, to provide assisted living services to the licensee's residents including medication administration.	01760		

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01760	Continued From page 35 ULP-B's employee record included medication training completed on May 17, 2023, and medication competency completed on June 17, 2023. On September 12, 2023, at 8:00 a.m., the surveyor observed ULP-B obtain medications for R3 from a locked medication cabinet, open the pharmacy packets which included benztropine 10mg, certavite 18-400mg-mcg, one half tab of chlorthalidone 25mg, docusate sodium 100mg, glipizide 2.5mg, metformin 1000mg, omeprazole 20mg, 2 tablets of senna time 8.6mg, vitamin D3 25mcg, Rybelsus 3mg., and place the medication into a medication cup. The surveyor then observed ULP-B obtain a medication planner for R1 that contained ten unidentified medications. ULP-B placed the ten medications into a separate medication cup and brought both R1 and R3's medications to the dining room table, and administered the medications to R1and R3 at the same time. The surveyor did not observe a medication count or verification of orders prior to administration. On September 12, 2023, at 8:07 a.m., the surveyor observed ULP-B obtain R2 medications from a locked cabinet, open pharmacy packets which contained famotidine 20 mg, oxcarbazepine 150 mg, acetaminophen 500 mg two tablets, baclofen 5mg, one tablet of cerovite senior, cetirizine 10 mg, and citalopram 10mg, place medication into pudding and administer medications to R2. The surveyor did not observe a medication count or verification of orders prior to administration. On September 12, 2023, at 8:14 a.m., the surveyor observed ULP-B document R1, R2, and R3's medications listed above as administered in	01760		

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01760	Continued From page 36 the EMAR. On September 12, 2023, at 8:21 a.m., ULP-B stated all medications are prepared in either medication planners, or in pharmacy prepared packets. In addition, ULP-B stated they knew the number of medications that had to be administered during the medication pass because they counted all medications prior to the surveyor's arrival. On September 12, 2023, at 8:24 a.m., ULP-B stated that their "boss" trained them in on medication administration and a competency test was completed after training. On September 12, 2023, at 11:31 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP were trained to count the number of medications on the electronic medication administration record (EMAR) and compare the number of medications in the preset bubble packs or medication planners. After completing a verification count, the medications are then administered to the resident. Documentation of administration is then completed in the residents' EMAR. The surveyor inquired what a ULP would do if a resident refused a medication. LALD/RN-A stated ULP could look up a medication picture located in the EMAR and call the nurse to assist with pill identification and then document which medication was refused. On September 13, 2023, from 7:42 a.m. to 7:56 a.m., the surveyor observed ULP-B administer benztropine 10mg, certavite 18-400mg-mcg, one half tab of chlorthalidone 25mg, docusate sodium 100mg, glipizide 2.5mg, metformin 1000mg, omeprazole 20mg, 2 tablets of senna time 8.6mg,	01760		

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01760	Continued From page 37 vitamin D3 25mcg, Rybelsus 3mg. ULP-B was observed dumping medications from bubble packs into a medication cup, and then handed the medication cup to R3 for self-administration. R3 was then observed consuming the medications provided to them by ULP-B. The surveyor did not observe a medication count or verification of orders prior to administration. On September 13, 2023, at 8:32 a.m., the surveyor observed ULP-B prepare medications for R1 utilizing a med planner. The surveyor observed ULP-B open the med planner, dump contents of med planner into a medication cup, and then handed the medication cup to R1 for self-administration. Surveyor observed R1 consume medications provided to them by ULP-B. ULP-B was then observed retrieving a laptop to document the medication administration. The laptop screen was black, in a locked mode, indicating that the computer could not have been used to verify medications prior to administration. The surveyor observed ULP-B unlock the laptop to document the medication administration. The surveyor did not observe a medication count or verification of orders prior to administration. The licensee's 7.08 Medication Management - Administration & Setup policy dated August 1, 2021, indicated that the nursing staff and unlicensed personnel trained to provide medication administration at Care Partners Homecare LLC will document any medication administration provided accurately in each resident record. Policy also indicates documentation of medication administration will be completed immediately after the task has been completed. Licensees 7.15 Medication &	01760		

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01760	Continued From page 38 Treatment-Administration & Delegation policy, dated August 1, 2021, indicated that the registered nurse (RN) must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39367	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	7517 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 39 Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 13, 2023, at 9:33 a.m., the surveyor conducted a review of the licensee's locked medication cabinet. The medication cabinet contained all medications administered to residents on a daily basis and was located in a central location in the facility. Resident specific medications were stored in separate baskets within this medication cabinet. The surveyor observed the following expired medications for R2: - Vanicream with an expiration date of July 26, 2023; - lidocaine 2.5% with an expiration date of October 23, 2021; and - prilocaine 2.5% with an expiration date of October 23, 2021. On September 12, 2023, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated typically they would send expired medications to the pharmacy for destruction, however, the licensee changed pharmacies after the previous pharmacy closed and they had been unable to return medications	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39367	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	7517 EDGEWOOD AVENUE NORTH BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 40 to the new pharmacy. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, read, "The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/11/23*
Time: 12:30:00
Report: 1025231212

Food and Beverage Establishment Inspection Report

Location:
CARE PARTNERS HOMECARE LLC
7517 EDGEWOOD AVENUE NORT
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: N409799
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

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

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Provide a thin-type probe thermometer for the kitchen.

Comply By: 09/13/23

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

Provide a means of verifying the dishwasher is sanitizing (interior contact temperature hot enough to sanitize).

Comply By: 09/20/23

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

During such time the kitchen is ever remodeled or updated, or cannot be maintained cleaned, provide smooth, durable, and easily cleanable surfaces for the kitchen.

Comply By: 09/11/23

Food and Equipment Temperatures

Type: Full
Date: *09/11/23*
Time: 12:30:00
Report: 1025231212
CARE PARTNERS HOMECARE LLC

Food and Beverage Establishment Inspection Report

Process/Item: Deli ham
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

Freezer in garage frozen maintained under fully framed ceiling

SINK USAGE
Facility has a two compartment sink
One compartment labeled for handwashing, the other for food
Facility does not have a dedicated food preparation sink separate from any warewashing

DISHWASHING
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) - use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
If the sanitize cycle on the dishwasher is unavailable, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)
Recommend having an alternative means of sanitizing available case of emergency or service interruption

COUNTERTOPS AND FOOD CONTACT SURFACES
Facility has polished stone countertops
Provide a smooth, non-porous food contact surface (e.g. cutting board) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher).
Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean but without the use of chemicals which may damage the finish. Do not use wood as a food contact surface.

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Reported the facility does not cook and cool food.

CFPM
Posted by entrance; discussed one CFPM per establishment

GENERAL COMMENTS
Discussed employee health and hygiene, illness exclusion
Food cook and holding temperatures, cross-contamination, raw meats and also packaged frozen food
Highly susceptible populations - no service or raw or undercooked animal food, eggs not Pasteurized,

discussed not batch cooking/scrambling eggs, cooking eggs fully
Provide a food thermometer with a thin-probe (e.g. a digital thermometer with the thin tip)
Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days); food date marked in the refrigerator
Discussed chemical label, use, and storage - look for "For Food Contact Surfaces" on chemical labels
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuseInformation on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

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 1025231212 of 09/11/23.

Certified Food Protection Manager: Tabitha Briggs

Certification Number: FM113885 Expires: 11/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231212

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	09/11/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

CARE PARTNERS HOMECARE LLC	**Address** 7517 EDGEWOOD AVENUE NORT	**City/State** Brooklyn Park, MN	**Zip Code** 55443	**Telephone**
License/Permit # N409799	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

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
	Surpervision			
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

		Safe Food and Water	COS	R
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	X	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		

		Proper Use of Utensils	COS	R
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	X	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: 09/11/23

Inspector (Signature)