DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 3, 2025

Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

RE: CCN: 245462
Cycle Start Date: April 3, 2025

Dear Administrator:

On May 30, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 16, 2025

Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

RE: CCN: 245462
Cycle Start Date: April 3, 2025

Dear Administrator:

On April 3, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 3, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 3, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/31/25 to 4/3/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/31/25 to 4/3/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54622781C (MN00108501). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food safety practices including proper food storage such as labeling and dating foods stored in the kitchen as well as monitoring the temperature of the dishwashers and refrigeration/freezer units and maintaining a sanitary work environment in the main kitchen and kitchenettes on the resident floors. This had the potential to affect 85/87 residents. Findings include: Food storage During the initial kitchen tour on 03/31/2025, at	F 812	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves the right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.	5/22/25

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F 812	Continued From page 2 7:17 a.m., the following items were discovered in the walk-in refrigerator without proper label/date; 12 Quart clear plastic square storage container with a blue lid 1/3 full of unknown cream colored liquid, a small, metal pan of pork cutlets- covered with plastic wrap, breaded meat in an uncovered, flat, metal pan, diced onions in clear plastic, square, covered container with plastic wrap, four separate small, metal pans - contained rice, mashed potatoes, chicken breast, and sliced zucchini as well as a sealed, plastic storage bag of raw hot dogs in in a small, metal pan, frozen shrimp in a large, metal pan covered with plastic wrap, cottage cheese in original container ½ full, and a large clear, plastic, covered container with mixed melons/grapes/pineapple. During an interview on 3/31/25, at 7:37 a.m., culinary director (CD)-A stated she expected staff to label cooked food items and containers when opened, before they were put in the walk-in refrigerator. Items needed to be used within five days of being cooked or opened. CD-A stated this was important, so expired food was not served to vulnerable residents. During an observation on 04/01/25, at 03:05 p.m., in the second-floor kitchenette, the reach in refrigerator had whipped topping in a partially used disposable, plastic tube with no cover on the open tip and no date label. A small amount of dried whipped topping was noted on outside of tube and the dispensing tip. During an interview on 4/3/25, at 10:06 a.m., corporate certified dietary manager (CDM)-B stated she expected items were labeled and dated when opened.	F 812	F812 Food Procurement Store/Prepare/Serve/Sanitary: Deficiency Summary: Food Storage During the initial kitchen tour, the following items were found unlabeled, undated, uncovered, or improperly stored: 12-quart clear plastic container with a blue lid, 1/3 full of unknown cream-colored liquid Small metal pan of pork cutlets, covered only with plastic wrap Breaded meat in an uncovered metal pan Diced onions in a plastic container with plastic wrap but no label Four small metal pans containing rice, mashed potatoes, chicken breast, and sliced zucchini Sealed plastic storage bag of raw hot dogs in a small metal pan Frozen shrimp in a large metal pan, covered only with plastic wrap Cottage cheese in its original container Large clear container with a fruit mix (melons, grapes, pineapple), not labeled On the second floor, the reach-in refrigerator contained:	

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F 812	Continued From page 3 Facility policy titled Labeling and Dating Policy (Ready to Eat and/or Potentially Hazardous Food) dated 05/2019, indicated ready to eat and potentially hazardous food items should be labeled and dated when opened. Kitchen Sanitation- During interview on 03/31/2025, at 7:54 a.m., CD-A stated they have tried to point out cleaning tasks to dietary staff with the intention tasks were completed when noticed. Facility implemented more cleaning recently; however, no check list/log had been developed for cleaning. During observation on 04/01/25, at 2:45 p.m., in the second-floor kitchenette the following items were noted; counter shelf above microwave had red syrup-like substance spilled on it, steam table had all pan lids soiled (both sides) with unknown dark brown substance as well as on removable stainless-steel divider bars. During observations on 04/01/25, at 3:11 p.m., the third-floor kitchenette ice and water machine had cloudy clear plastic ice dispenser chute and water tube had an unknown brownish colored substance inside. During observations 04/01/25, at 3:11 p.m. and 04/02/25, at 10:21 a.m. the third-floor steam table had all pan lids soiled (both sides) with unknown dark brown substance and unknown dark, brown substance on each divider bar. During observations on 04/02/25, at 10:26 a.m., the second-floor steam table had all pan lids soiled (both sides) with unknown dark brown substance and removable stainless-steel divider	F 812	A partially used disposable whipped topping tube with no cover on the dispensing tip No date label on the whipped topping Dried product residue on the outside and dispensing tip of the tube Plan of Correction: All issues cited during the survey were immediately addressed and corrected during the survey. Nutrition & Culinary staff will be re-educated on proper food labeling, dating, and storage in accordance with our current, and up to date, Labeling and Dating Policy. To ensure continued compliance, weekly audits have been implemented for a duration of 4 weeks. These audits focus on verifying that all food items are labeled, dated, and appropriately packaged. Findings from weekly audits will be reported to the QAPI team. The QAPI team will determine appropriate audit frequency based on compliance trends and results. This deficiency has been added to the QAPI tracking log for discussion at the next monthly meeting. Deficiency Summary: Kitchen Sanitation:	

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F 812	Continued From page 4 bars had unknown dark brown substance on each. bar Additionally, the swinging doors contained built up fingerprints and general soiled appearance, sticky to touch. During interview and observation with CDM- B, on 04/03/25, at 09:56 a.m., the third-floor floor steam table had all pan lids soiled (both sides) with unknown dark brown substance and removable stainless-steel divider bars had unknown dark, brown substance on each bar. Additionally, the ice and water machine had a cloudy clear plastic ice dispenser chute and water tube had an unknown brownish colored substance inside. CDM-B confirmed presence of brown substance. CDM-B stated she expected kitchen staff would oversee cleaning the beverage station. The beverage station, in the current state, did not meet CDM-B's expectations. Facility document titled Infection Prevention and Control Manual, Dietary Department, page 13-3 Dated 2020 from Pathway Health Services section H. Cleaning Procedures: a.) Dietary department is cleaned on a regular schedule and logs are maintained. Temperature Logs: During an interview on 03/31/25, at 1:29 p.m., the kitchen supervisor (KS)-C stated CD-A, himself and the day supervisor were responsible for ensuring the logs were completed. KS-C also stated it was important to make sure the logs are completed because they bring food to different areas upstairs where residents are served. Review of the 3/2025, Temperature Logbooks from the kitchenettes on the second and the third	F 812	Surveyors observed the following sanitation issues: No formal cleaning checklist was in place at the time of survey. Second-floor kitchenette observations included: Sticky red syrup-like substance spilled on the counter shelf above the microwave Steam table pan lids and removable stainless-steel divider bars heavily soiled on both sides with unknown dark residue Third-floor kitchenette and steam table observations included: Ice and water machine with cloudy ice chute and brownish buildup in the water tube All steam table pan lids and divider bars soiled with unknown dark brown substance Second-floor steam table and surrounding areas: All pan lids and divider bars soiled with unknown brown substance Swinging doors had visible buildup, fingerprints, and were sticky to the touch	

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F 812	Continued From page 5 floor which were stored under counters had missing several entries for month of March, dishwasher temp and fridge freezer temp logs each missing several entries. Record review of March 2025 temperature logs noted the following information: Main kitchen - - Dish machine temperature log was missing 27/93 entries with an additional 7 entries that were below the required temperature. - Walk-in refrigerator log was missing 15/31 entries - Walk-in freezer log was missing 14/31 entries. Gables one kitchenette- - Reach-in refrigerator was missing 8/31 entries for the morning shift and 9/31 entries for evening shift. - Dish machine included eight missing entries for wash temperature for breakfast shift and 8 missing entries for rinse temperature for breakfast shift. - Dish machine over the noon hour was missing nine entries for wash and nine entries for rinse temperatures. - Dish machine for the evening meal wash included 15 missing entries and one reading below required temperature, and 11 missing entries for rinse temperatures. Facility policy Infection Prevention and Control Manual, Dietary Department page 13-2 Section E 2 f. indicates High temperature dish machine water temperature should be at least 150 degrees F or according to manufacturer's specifications. Rinse temperature will reach at least 180 degrees or manufacturer's instructions.	F 812	Plan of Correction: All issues cited during the survey were immediately addressed and corrected during the survey. Culinary staff will complete training sessions on the requirements of kitchen sanitation and infection prevention Education to include review of the Infection Prevention and Control Manual and Cleaning Procedures for the Dietary Department. The Infection Prevention and Control Manual and dietary cleaning procedures have been reviewed and confirmed current and up to date. Daily and weekly cleaning checklists have been revised to reflect current sanitation expectations, and all culinary staff will be educated on their proper use and documentation requirements. Checklists updated to include cleaning expectations for: Steam tables: Wipe down surface of the steam table after each meal; steam table lids and divider bars are to be removed and washed after every meal Ice and water dispensers: External surfaces wiped down daily; scheduled internal cleaning by maintenance per manufacturer guidelines	

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F 812	Continued From page 6 Hair Nets: During initial kitchen observation and interview on 03/31/25, at 7:40 a.m., a volunteer, with blonde/gray hair was noted to have no hair covering, was walking throughout the kitchen including cooks' area where the cook was preparing food, dish room, storage area CD-A stated she expected hairnets worn in the kitchen by everyone in the kitchen regardless of their reason for being in the kitchen. CD-A stated it was very important everything must be sanitized. She expected everyone to wear one and expected the whole head of hair to be covered. Observation made on 04/03/25, at 09:45 a.m., in the main kitchen, an unidentified cook was observed wearing a hairnet on top of hair, back of hair down past shoulders, was not contained within the hairnet. Observation and interview on 04/03/25, at 09:58 a.m., an unidentified nursing assistant (NA) entered the kitchenette on third floor without wearing a hair net. NA was observed preparing toast for a resident behind the kitchenette counter. When NA was asked by CDM-B if there were hairnets available, the NA was not aware of hairnet rules or location. CDM-B stated it was expectation that all staff be wearing hairnets that cover all hair in any food prep areas, and stated the facility has had challenges with nursing staff coming in and out of kitchenettes without hair covering. Review of facility policy, Nutrition & Culinary Uniform Policy revised 10/31/2024, stated that all staff must wear hair restraints while preparing	F 812	Swinging doors and high-touch surfaces: Cleaned and sanitized daily, including both sides of wooden swing doors and all door handles Walls, counters, and shelving: Wipe down all surfaces in the serving area and kitchenette daily Refrigerators and freezers: Wipe fronts daily, clean up any internal spills, and check for expired items to discard and dates/labels Audits will be completed weekly for 4 weeks to ensure cleanliness and proper use of checklists in all areas, including the main kitchen and kitchenettes. Findings from weekly sanitation audits will be reported to the QAPI team. The QAPI team will determine appropriate audit frequency based on compliance trends and results. This deficiency has been added to the QAPI tracking log for discussion at the next monthly meeting. Deficiency Summary: Temperature Logs Surveyors observed the following: Second and Third Floor temperature logbooks were missing several entries for the month of March. Dishwasher Temp and Fridge Freezer temperature logs each missing several entries.	

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F 812	Continued From page 7 food in prep areas to prevent hair from contacting/contaminating food. Additionally, the policy identified areas behind the cook line, kitchenettes where staff are serving food, and special events where staff would be preparing food.	F 812	Second and Third Floor Kitchenettes (March 2025): Missing multiple entries in both the dishwasher temperature log and the refrigerator/freezer logs. Main Kitchen: Dish machine temperature log was missing entries, with seven recorded temperatures below required standards. Walk-in refrigerator and walk-in freezer logs also contained multiple missing entries. First Floor Kitchenette: The reach-in refrigerator was missing entries for morning and evening shifts. Dish machine logs were missing wash and rinse temperature entries for breakfast, lunch, and dinner. One recorded temperature during evening service was below the required standard. Plan of Correction: All issues cited during the survey were immediately addressed Inventory of thermometer placement in fridges and freezers was completed Staff will be educated on the mandatory requirements for checking and	

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F 812	Continued From page 8	F 812	documenting temperatures of refrigerators, freezers, and dishwashers. Training will include a review of the proper procedure for recording temperatures and the steps to take when temperatures fall outside of acceptable ranges. Required temperature guidelines to be reviewed with staff: Refrigerators: 41°F or below Freezers: 0°F or below Dishwasher – Wash Cycle: 150°F or above Dishwasher – Rinse Cycle: 180°F or above Dish surface (ware) temperature: 160°F or above Temperature log audits will be conducted weekly for 4 weeks across all areas (main kitchen and kitchenettes). These audits will ensure: Entries are made consistently across all shifts. Any out-of-range temperatures are identified and addressed immediately Audit findings will be reported to the QAPI team, who will evaluate the need for continued auditing or further process	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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F 812	Continued From page 9	F 812	changes. This deficiency has been added to the QAPI tracking log and will be reviewed at the next scheduled monthly meeting. Deficiency Summary: Hairnets Surveyors observed the following: During the initial kitchen walk through, a volunteer was noted to have no hair covering and walking through the kitchen including the cooks area where food was being prepared. Additionally, a cook was observed wearing a hairnet on top of her hair, the back of her hair was down past her shoulder and the hair was not contained within the hairnet. On the third-floor kitchenette, a nursing assistant entered the food prep area without a hair net and was unaware of the requirement. No hair nets were available in the area at the time. Plan of Correction: All issues cited during the survey were immediately addressed and corrected. Staff have been coached on the use of hairnets that were cited in the survey. Hairnets are now readily available in the main kitchen and have been stocked in every household kitchenette to ensure access for all staff, including nursing and volunteers.	

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	245462	A. BUILDING _____ B. WING _____	C 04/03/2025

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F 812	Continued From page 10	F 812	All staff, including Nutrition and Culinary team members, volunteers, and nursing staff, will be educated on the Nutrition and Culinary Uniform Policy, which includes: The mandatory use of hairnets in all food prep areas Hairnets must fully cover all hair, including ponytails and buns Hairnets are also required behind steam tables and during special events where staff are preparing or plating food Hairnet compliance will be audited weekly for 4 weeks across all food service areas and kitchenettes. Audit results will be reported to the QAPI team, who will determine the ongoing frequency of audits based on compliance trends. This issue has been added to the QAPI tracking log for discussion at the next monthly meeting. The Nutrition and Culinary Director or designee will be responsible for ongoing monitoring and ensuring staff adherence to food procurement, store/prepare/serve-sanitation.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 16, 2025

Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

Re: Event ID: NOG211

Dear Administrator:

The above facility survey was completed on April 3, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	C 04/03/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/31/25 to 4/3/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed:	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	C 04/03/2025

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2 000	Continued From page 1 H54622781C (MN00108501). NO citations were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **02 - MAIN BULIDING** B. WING _____	**03/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/31/2025. At the time of this survey, Maranatha Care Center building 2 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/25/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Maranatha Care Center (Building 2) is a 3-story building with no basement that was built in 2013 and was determined to be of Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The building is attached to the Kitchen and Chapel which was determined to be of Type V(111) construction.	K 000		

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	245462	A. BUILDING **02 - MAIN BULIDING** B. WING _____	**03/31/2025**

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K 000	Continued From page 2 There is a 2-hour fire rated wall separating the two buildings and will therefore be surveyed as two buildings. A 2-hour wall also separates the care center from an assisted living and independent living facilities. The facility has a capacity of 97 beds and had a census of 89 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363		5/22/25

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K 363	Continued From page 3 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 03/31/2025 at 10:35 AM, it was revealed by observation that the door to the office suite on the third floor was propped open with a wooden wedge. 2. On 03/31/2025 at 11:08 AM, it was revealed by observation that the door to resident room 126 would not positively latch. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 363	To meet the requirement to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10., the Environmental Services Director (ESD) or his designee will: Remove the wedge holding the 3rd-floor office suite corridor door open was completed on 03/31/2025 . The Environmental Services Director (ESD), Regional Engineering Manager (REM), or designee will educate all staff of the requirement for corridor doors not to have wedges holding them open. The ESD will train the maintenance and housekeeping staff to be alert for doors propped open with wedges. The ESD or designee will inspect the care center for doors propped open with wedges for 4 weeks and then during the scheduled monthly Fire Door Inspection task that is entered into the Electronic Work Order	

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K 363	Continued From page 4	K 363	System (EWOS). The corridor door to resident room 126 will be made to latch as per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10,was completed on 3/31/2025. By 5/22/2025 all doors will be checked and fixed. The ESD will audit all doors monthly with the monthly fire door inspection.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923		5/22/25

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K 923	Continued From page 5 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.6 and 11.6.2.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/31/2025 at 10:39 AM, it was revealed by observation that one green oxygen cylinder was not in a stand or a cart in the oxygen room on the third floor. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 923	The ESD will ensure that there is adequate containment in the O2 room for all O2 cylinders on 3/31/2025. A recurring task will be added to the Electronic Work Order System (EWOS) by the REM on or before 4/30/2025 for a monthly inspection of O2 room(s) to ensure they meet the requirements of NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.6 and 11.6.2.3 for O2 storage. The ESD will be responsible for ensuring this monthly task is completed on schedule. Education for nursing staff on proper storage of O2 will be completed by DON or designee by 5/22/2025.	

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	245462	A. BUILDING **03 - KITCHEN AND CHAPEL** B. WING _____	**03/31/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/31/2025. At the time of this survey, Maranatha Care Center building 3 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Maranatha Care Center (Building 3) is a 1-story building with no basement that was built in 2013 and was determined to be of Type V(111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The building is attached to the Main Building which was determined to be of Type II(222) construction. There is a 2-hour fire rated wall separating the two buildings, and will therefore be surveyed as two buildings. A 2-hour wall also separates the care center from an assisted living and independent living facilities. The facility has a capacity of 97 beds and had a census of 89 at time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245462	A. BUILDING **03 - KITCHEN AND CHAPEL** B. WING _____	**03/31/2025**

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K 000	Continued From page 1 The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		