Electronically Delivered
November 21, 2023

Licensee
Better Living Residential Care
801 Selby Avenue
Saint Paul, MN 55104

RE: Project Number(s) SL36891015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH 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).

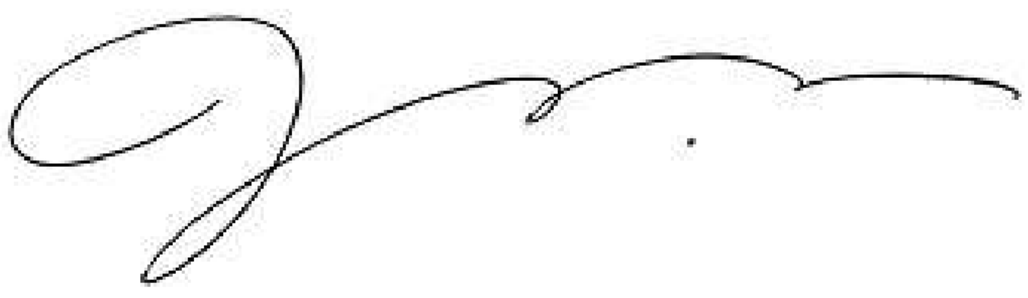
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55164

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36891	A. BUILDING: _____ B. WING _____	11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER LIVING RESIDENTIAL CARE	801 SELBY AVENUE SAINT PAUL, MN 55104

(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: SL36891015 On October 30, 2023, through November 1, 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 2 active residents; all of whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 30, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 2 (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 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 observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all of the required content defined in Appendix Z. In addition, the licensee failed to evaluate/revise the missing resident plan at least quarterly. This had the potential to affect all two residents receiving services under the assisted living license, 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	0 680		

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0 680	Continued From page 3 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on October 30, 2023, at 11:50 a.m., the emergency preparedness binder was given to the surveyor for review. The emergency preparedness binder included a Hazard Vulnerability Assessment (HVA) dated January 2023 which was noted as prepared by (LALD/CNS)-A. The EPP lacked the following required content: - hazard vulnerability assessment to include an all-hazards approach with probable risks/hazards by likelihood of occurrence; - documentation of a missing resident plan that is reviewed quarterly; - a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency program (EP) to maintain integrated response; - development of policies/procedures to address whether evacuated or shelter in place for staff/residents: - food, medical supplies, pharmaceutical supplies; - alternative sources of energy to maintain: - temperatures to protect resident health/safety; and - safe/sanitary storage of provisions. - sewage and waste disposal -policy/procedure to track the location of on-duty staff and sheltered residents, and if relocated to	0 680		

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0 680	Continued From page 4 document the specific name/location of the receiving facility or other location; - policy/procedure to address safe evacuation from the facility including staff responsibilities, transportation, identification of evacuation locations; - policy/procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy/procedure to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy/procedure to address the use of volunteers, including the process/role for integration; - policy/procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - a communication plan that included: - names/contact information of staff, entities providing services under the agreement, residents' physicians, other facilities, volunteers, Federal, State, tribal, regional EP staff, State Licensing and Certification Agency, and MN Office of Ombudsman for Long Term Care; - means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); - means of providing information about general condition/location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4); - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - method for sharing information from the emergency plan, that the facility has determined	0 680		

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0 680	Continued From page 5 appropriate, with residents and their families/representatives; - EP training and testing program; and - EP testing/annual testing requirements. On November 1, 2023, at 11:55 p.m., (LALD/CNS)-A stated she reviewed the binder annually and assumed the template she purchased and used had all of the required content. (LALD/CNS)-A stated she would be contacting the consulting group and getting an updated template that would need to be completed to meet compliance. Minnesota Rules 4659.0100 dated August 11, 2021, stated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. Minnesota Rules 4659.0110, Subp. 4. dated August 11, 2021, stated review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. The licensee's emergency preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy also referenced	0 680		

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0 680	Continued From page 6 Appendix Z requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, 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:	0 790		

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0 790	Continued From page 7 On October 30, 2023, from 2:30 p.m. to 3:30 p.m., survey staff toured the facility with the licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A. During the tour, survey staff observed that both portable fire extinguishers in the facility lacked a current tag or any documentation showing the required annual service date, and also lacked any tag or documentation showing the required monthly visual inspections to date. Both fire extinguishers in the facility had last been certified in April of 2021. LALD/CNS-A visually verified this deficient finding at the time of discovery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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.	0 810		

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0 810	Continued From page 8 (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to provide required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, 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).	0 810		

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0 810	Continued From page 9 Findings include: A record review and interview were conducted on November 1, 2023, with the licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to evacuate the building but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, LALD/CNS-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD/CNS-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD/CNS-A verified that the fire safety and	0 810		

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0 810	Continued From page 10 evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD/CNS-A stated the licensee did not have any documentation on training employees because they were doing the training at the same time as the evacuation drills. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, LALD/CNS-A stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan because they would have residents participate in the evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract;	0 930		

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0 930	Continued From page 11 (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This had the potential to affect all current 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: R2's diagnoses included autism spectrum disorder, major depression, anxiety, attention deficit hyperactivity disorder, and asthma. R2's Service Plan dated October 1, 2023, noted services including assistance with socialization, security checks, transportation, meal preparation, laundry, housekeeping, hygiene, dressing and	0 930		

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0 930	Continued From page 12 bathing reminders and medication management. R2's Assisted Living Contract signed on January 5, 2023, lacked the following required content: - a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints; - the right under section 144G.54 to appeal the termination of an assisted living contract; and the facility's policy regarding transfer of residents within the facility, under which resident consent is required for a transfer. On November 1, 2023, at 11:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the contract did not include the above required content and they would be updating the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36891	A. BUILDING: _____ B. WING _____	11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER LIVING RESIDENTIAL CARE	801 SELBY AVENUE SAINT PAUL, MN 55104

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0 950	Continued From page 13 "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one resident's (R2) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect the licensee's current 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:	0 950		

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0 950	Continued From page 14 R2's diagnoses included autism spectrum disorder, major depression, anxiety, attention deficit hyperactivity disorder, and asthma. R2's Service Plan dated October 1, 2023, noted services including assistance with socialization, security checks, transportation, meal preparation, laundry, housekeeping, hygiene, dressing and bathing reminders and medication management. R2's Assisted Living Contract signed by R2 on January 5, 2023, noted on page 19 "Resident has the right to name an individual of their choice as 'Designated Representative' for the purposes of receiving certain information and to whom Provider can go to with questions related to Resident's residency and care at [licensee]. If a Responsible Person is party to this Contract and Resident fails to name and provide contact information for a Designated Representative, Provider will direct questions related to Resident's residency and care at [licensee] to the Responsible Person. Resident may name as Resident's Designated Representative an individual serving as Resident's Responsible Person. Resident also has the right to decline to name a Designated Representative, regardless of whether an individual has agreed to execute this Contract as Resident's Responsible Person." R2's contract lacked the following required verbatim notice: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated	0 950		

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0 950	Continued From page 15 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On November 1, 2023, at 11:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the contract lacked the right to designate a representative verbatim notice, and further stated the same contract format was utilized for all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a	0 970		

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0 970	Continued From page 16 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 the potential to affect a large portion or all the residents). The findings include: The licensee's undated Assisted Living Contract included the following clauses which indicated the resident would waive the licensee's liability for health, safety, or personal property of the resident. - VI. General Terms section 2., page 14 of the contract "INDEMNIFICATION Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents. - VI. General Terms section 4. page 15 of the contract, "LIABILITY Provider is not liable to Resident ... for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident... Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other	0 970		

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0 970	Continued From page 17 loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." On November 1, 2023, at 11:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the contract did include a liability waiver and was developed by a lawyer. (LALD/CNS)-A stated she was going to have the contract updated and the liability language removed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced	01560		

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01560	Continued From page 18 by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, the dementia care training program with the required content. 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: The licensee's undated Dementia Disclosure Statement noted all direct care staff and supervisors would be trained on topics including an explanation of Alzheimer's disease and related disorders, how to provide assistance with activities of daily living, effective approaches to use to problem solve with challenging behaviors, how to communicate with residents with Alzheimer's disease or other dementias, and how to provide assistance with daily living. However, it lacked the inclusion of person-centered planning and service delivery. On November 1, 2023, at 11:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the dementia disclosure did not contain the required content and they would be updating it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01560		

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01560	Continued From page 19 (21) days	01560		
01620 SS=F	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 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool for one of one resident (R2). This practice resulted in a level two violation (a	01620		

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01620	Continued From page 20 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2's diagnoses included autism spectrum disorder, major depression, anxiety, attention deficit hyperactivity disorder, and asthma. R2's Service Plan dated October 1, 2023, noted services including assistance with socialization, security checks, transportation, meal preparation, laundry, housekeeping, hygiene, dressing and bathing reminders and medication management. R2's Monitoring and Reassessment form dated January 18, 2023, identified as a 14-day assessment, included personal cares, height, weight, transfers, ambulation, toileting, mobility, bowel and bladder continence, dentures, glasses, hearing aids, exercise, behaviors, pain, smoking, skin issues, medication assistance, laundry/housekeeping, and maintenance of a clean and safe environment. However, the assessment lacked all the elements of the universal assessment tool. R2's Monitoring and Reassessment form dated April 5, 2023, identified as a 90-day assessment, included personal cares, height, weight, transfers, ambulation, toileting, mobility, bowel and bladder continence, dentures, glasses, hearing aids, exercise, behaviors, pain, smoking, skin issues, medication assistance, laundry/housekeeping, and maintenance of a clean and safe	01620		

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01620	Continued From page 21 environment. However, the assessment lacked all the elements of the universal assessment tool. R2's Monitoring and Reassessment form dated July 4, 2023, identified as a 90-day assessment, included personal cares, height, weight, transfers, ambulation, toileting, mobility, bowel and bladder continence, dentures, glasses, hearing aids, exercise, behaviors, pain, smoking, skin issues, medication assistance, laundry/housekeeping, and maintenance of a clean and safe environment. However, the assessment lacked all the elements of the universal assessment tool. On November 1, 2023, at 11:55 a.m., Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the monitoring and reassessment form was utilized for the 14-day assessment and a 90-day assessment, and did not include all of the required elements. LALD/CNS-A stated she would start using the electronic record version of the assessments in R-task to be sure all areas are included in all assessments. Minnesota Rules 4659.0150 dated August 11, 2021, stated each licensee must develop a uniform assessment tool. The licensee may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. The licensee's Nursing Assessment policy dated January 1, 2023, noted the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment.	01620		

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01620	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 23 by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for one of one resident (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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included autism spectrum disorder, major depression, anxiety, attention deficit hyperactivity disorder, and asthma. R2's Service Plan dated October 1, 2023, noted services including assistance with socialization, security checks, transportation, meal preparation, laundry, housekeeping, hygiene, dressing and bathing reminders and medication management. The service plan lacked: - the schedule and method of monitoring assessments of the resident; - the methods of monitoring staff providing services; and - a contingency plan that included the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On November 1, 2023, at 11:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the schedule and method	01650		

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01650	Continued From page 24 of monitoring assessments of the resident contained the verbiage from the comprehensive home care license templates, and lacked the methods of monitoring staff as well as the required portion of the contingency plan noted above. LALD/CNS-A stated she relied too much on the materials provided by the paid consulting group. The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include the schedule and methods of monitoring reviews or assessments of the resident, the schedule and method of monitoring staff providing services, and a contingency plan including the circumstances in which emergency medical services were not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/30/23*
Time: 15:01:51
Report: 1021231344

Food and Beverage Establishment Inspection Report

Location:
Better Living Residential Care
801 Selby Avenue
St Paul, MN55104
Ramsey County, 62

Establishment Info:
ID #: 0038873
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9528552098
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

UNABLE TO FIND EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH MANAGER. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 11/01/23

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPEN GALLON OF MILK AND OPEN CARTON OF HEAVY WHIPPING CREAM IN THE REFRIGERATOR WERE FOUND WITHOUT A DATE MARK. PER CONVERSATION WITH STAFF, THEY WERE OPENED ON FRIDAY. DISCUSSED DATE MARKING AND STAFF DATE MARKED TCS FOOD ITEMS. CORRECTED ON-SITE.

Comply By: 10/30/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 11/06/23

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) EMPLOYED AT THIS ESTABLISHMENT. FAID ALI ALREADY COMPLETED THE FOOD SAFETY CLASS AND PASSED THE EXAM. FAID IS IN THE PROCESS OF RECEIVING HER CFPM CERTIFICATE.

Comply By: 11/10/23

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: Degrees Fahrenheit - Location: MILK - KITCHEN REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH FOOD PROGRAM MANAGER, FAID ALI AND HEALTH REGULATION DIVISION NURSE EVALUATOR, ROCHELLE FOX.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 2 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH FAID, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

DISH MACHINE ON-SITE DOES MEET THE RESIDENTIAL ANSI/NSF 184 STANDARD.

ESTABLISHMENT HAS A MEASURING DEVICE ON-SITE FOR THE DISH MACHINE BUT IT IS A DIGITAL THERMOMETER. THE DISH MACHINE IS RESIDENTIAL AND THE CYCLE IS 1+ HOURS LONG. DISCUSSED WITH MANAGER THAT THEY NEED A THERMOLABEL TO ACCURATELY MEASURE THE FINAL UTENSIL SURFACE TEMPERATURE. THERMOLABELS LEFT ON-SITE AND MANAGER WILL SEND A PICTURE TO INSPECTOR THROUGH E-MAIL.

ESTABLISHMENT DOES NOT HAVE A PREPARATION SINK ON-SITE. NO WASHING OR PROCESSING OF PRODUCE CAN BE PREPARED ON-SITE. ALL PRODUCE MUST BE PURCHASED PRE-WASHED/PRE-CUT FROM AN APPROVED SUPPLIER OR PROCESSED AT AN APPROVED COMMISSARY KITCHEN.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD FLOORING, LAMINATE COUNTERTOPS, WOOD CABINETS AND POPCORN CEILING. EQUIPMENT AND PHYSICAL

Type: Full
Date: *10/30/23*
Time: 15:01:51
Report: 1021231344
Better Living Residential Care

Food and Beverage Establishment Inspection Report

FACILITIES WILL BE MONITORED AT FUTURE INSPECTIONS.

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 1021231344 of 10/30/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

FAID ALI
FOOD PROGRAM MANAGER

Signed:_____

Melissa Ramos
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