June 28, 2023

Licensee
Blessed Hands Health Care, LLC
8465 79th Street South
Cottage Grove, MN 55016

RE: Project Number(s) SL37831015

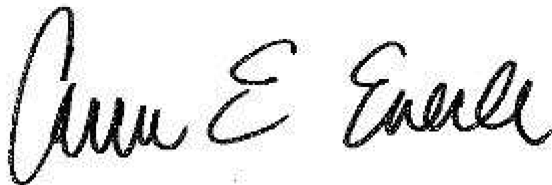
Dear Licensee:

On June 5, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 28, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Carrie Euerle, Supervisor
State Evaluation Team
Email: carrie.euerle@state.mn.us
Telephone: 651-201-5984 Fax: 651-281-9796

PMB

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 11, 2023

Licensee
Blessed Hands Health Care LLC
8465 79th Street South
Cottage Grove, MN 55016

RE: Project Number(s) SL37831015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial evaluation on March 28, 2023, assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

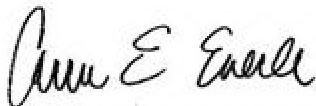
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,



Carrie Euerle, Supervisor
State Rapid Response Team / State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 64970 / P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Email: carrie.euerle@state.mn.us
Telephone: 651-242-8846 Fax: 651-215-6894 / 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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: SL37831015 On March 27, 2023, through March 28, 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 two residents receiving services under the provider's Provisional Assisted Living Facility license. An immediate correction order was identified on March 28, 2023, issued for SL37988015-0, tag identification 0820. On March 29, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 450	Continued From page 1	0 450		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement received for two of two residents (R1 and R2). 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: R1 started receiving services from the licensee on February 28, 2023, for assistance with bathing, behavior observation, and medication	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(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
0 450	Continued From page 2 administration. R1's record lacked evidence a copy of the updated Assisted Living Bill of Rights was provided to the resident/representative. R2 started receiving services from the licensee on February 14, 2023, for assistance with bathing, dressing, behavior observation, medication administration, and transferring. R2's record lacked evidence a copy of the updated Assisted Living Bill of Rights was provided to the resident/representative. On March 28, 2022, registered nurse (RN)-B provided the surveyor with a document(s) titled Home Care Bill of Rights and Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers. On March 28, 2023, RN-B confirmed R1 and R2 did not have an updated Assisted Living Bill of Right in their records. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 470	Continued From page 3 unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a staffing plan to determine staffing levels to meet the needs of all residents and ensure the plan was developed, implemented, and posted as required. This had the potential to affect all two residents, (R1 and R2), staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 470	Continued From page 4 portion or all of the residents). The findings include: The licensee holds an assisted living facility license and is licensed for a bed capacity of four residents, with a current census of two residents. During the facility tour on March 27, 2023, registered nurse (RN)-B confirmed the licensee employs three unlicensed personnel at the survey location. RN-B stated staffing schedules are written by RN-B with input from administrator (AD)-A. RN-B stated there is no "matrix or plan", that scheduling is based on the licensee's census and needs. The licensee policies 6.15 Staffing Requirements - licensed nurse and ULP was provided upon request. On March 28, 2023, RN-B confirmed a schedule is completed, but that there is no staffing plan or matrix used by licensee. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ____ B. WING ____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 480	Continued From page 5 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 included document titled, Food and Beverage Establishment Inspection Report dated March 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(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
0 510	Continued From page 6	0 510		

Continued From page 6

compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure appropriate personal protective equipment (PPE) was worn for two of two employee (administrator (AD)-A, and registered nurse (RN)-B) when observed. This had the potential to affect all residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:

On March 27, 2023, at 10:00 a.m., while surveyor entered facility and completed general observations around the common areas of the facility, AD-A and RN-B were noted to be working with no face mask and their full face exposed. The staff corrected the placement of their face masks when noted the surveyor's presence.

The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 510	Continued From page 7 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The licensee's 8.01 Infection Control policy, date January 18, 2023, indicated the facility would identify areas where infection control practices are necessary based on the exposure and risk of the facility. The infection control program indicated it will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The CDC COVID Data Tracker on March 27, 2023, indicated Washington County, MN (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents. On March 27, 2023, RN-B acknowledged the employees were not following the licensee's infection control expectations and policies. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality	0 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 580	Continued From page 8	0 580		

management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to engage in and maintain documentation on quality management activities appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).

Findings include:

During an interview on March 27, 2023, a copy of the facility's quality management plan was requested from the administrator (AD)-A, who verified the licensee had not completed a documented quality management activity.

The licensee's 2.31 Quality Management Project policy, contained required content related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(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
0 580	Continued From page 9 Minnesota statute 144G.42 subd. 2 which indicated the licensee will have at least one documented quality management project in place at all times and retain records of such projects for at least two years. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 580		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 650	Continued From page 10 by: Based on interview and record review, the licensee failed to ensure the employee record included all required content for two of two employees (unlicensed personnel (ULP)-C, ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was hired to provide assisted living services on February 15, 2023. ULP-C's employee record did not contain documentation of a job description provided to ULP-C. ULP-D ULP-D was hired to provide assisted living services on March 8, 2023. ULP-D's employee record did not contain documentation of a job description provided to ULP-D. On March 28, 2023, licensed assisted registered nurse (RN)-B verified ULP-C and ULP-D's records lacked a job description and stated the licensee's policy required a job description to be included in the employee file.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 650	Continued From page 11 The licensee's Employee Records policy directed the employee file contain a current job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 680	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all the required components included in Appendix Z. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On March 27, 2023, the surveyor requested the licensee's emergency preparedness plan and components from registered nurse (RN)-B. The licensee's Fire and Emergency Evacuation Plan lacked the following required content: -EP patient population -subsistence needs for residents and staff -policies and procedures for medical documents -policy and procedures for volunteers -arrangement with other facilities -roles under a waiver declared by Secretary -development of communication plan -names and contact information -emergency officials contact information -primary/alternate means of communication -methods for sharing information -sharing information on occupancy/needs -family notifications During an interview on March 28, 2023, RN-B	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(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
0 680	Continued From page 13 verified not having the required information or all required components of Appendix Z. RN-B verified she understood the requirement that the licensee will have in place an emergency preparedness plan that is in alignment with facility's requirement to comply with CMS Appendix Z, however the licensee's Emergency Preparedness Plan had not been completed. Also, the licensee's undated Emergency Response, Reporting & Review Policies, indicated it is the intent of the facility to effectively respond to, report, and review all emergencies to ensure the safety of persons receiving services and to promote the continuity of services until emergencies are resolved, and has in place an effective and compliant Emergency Preparedness Plan. The licensee was able to produce current copy of the facilities Disaster Planning and Emergency Preparedness policies but failed to submit a completed plan during the survey process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 800	Continued From page 14	0 800		

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff.

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 are:

On March 28, 2023, approximately from 10:50 am to 11:40 a.m., survey staff toured the home with the administrator (AD)-A. The registered nurse (RN) joined the tour at 11:15 a.m. During the home tour, survey staff observed the following:

1. Egress Windows
- The AD-A opened the encasement-type egress window in resident room # 1 (unoccupied) on the main level for measurement and survey staff measured the clear window opening with a width dimension of 16 inches and height of 48 inches. Survey staff explained to the AD-A that the window with a clear opening of 16 inches failed to meet the minimum state standard width of 20 inches for the egress window due to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(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
0 800	Continued From page 15 obstruction of the window once the egress window is in the fully opened position. -The clear opening width of the encasement-type egress windows in the basement bedrooms #4 and #5 (both unoccupied) failed to meet the minimum state standard requirement of 20 inches in clear width opening for egress. Bedrooms #4 and #5 egress windows were measured with a width of 17.5 inches (and 37 inches in height) in the opened position. Existing egress windows must meet the minimum clear window opening width of 20 inches with a required minimum height of 32.5 inches totaling minimum net clear opening of 648 square inches. 2. Window Hardware The window hardware for the basement bedrooms #4 and #5 was not easily and readily operable for immediate use. After multiple attempts by the AD-A, the windows opened. In addition, the window hardware for bedroom #4 was disconnected from the window track and the AD-A had difficulty closing the windows. Survey staff explained to the AD-A that egress windows must be operable and openable for immediate use. The above findings were verbally and/or visually verified by the AD-A accompanying the tour. 3. A deadbolt lock hardware that may require a key to unlock the door from the basement stairway of the home to the main-level floor for egress. Survey staff explained that the deadbolt lock hardware in the means of egress that require a key to exit will cause delay and impediment in the proper exiting of the basement of the home to the main floor during a fire or similar emergency and violate state codes. The AD-A stated that they can remove the deadbolt lock hardware. 4. Lack of an approved cigarette butt receptor (device) for proper disposal of cigarette butts. The finding was evident as survey staff observed	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 800	Continued From page 16 an approximately 6-inch metal can placed outside on the deck for discarding cigarette butts. The AD-A confirmed the finding. On March 28, 2023, at approximately 1:10 p.m., during the exit interview, the AD-A and the RN-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ____ B. WING ____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(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
0 810	Continued From page 17	0 810		

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 observation, record review, and interview, the licensee failed to provide the complete content of the fire safety and evacuation plan, and the minimum required training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On March 28, 2023, approximately from 10:50 am to 11:40 a.m., survey staff toured the home with the administrator (AD)-A. The registered nurse (RN) joined the tour at 11:15 a.m. At approximately noon, survey staff received the facility fire safety and evacuation plan and related documentation for review from the registered nurse (RN)-B.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ____ B. WING ____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 810	Continued From page 18 At approximately 1:00 p.m., document review and interview with the administrator and the RN-B and the administrator (AD)-A indicated the following: 1. The posted evacuation floor layout and sign posted near the garage door of the home incorrectly label the garage door as an approved exit. 2. Document review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation during a fire or similar emergency. Unique resident needs during emergency movement or an evacuation may be residents who have mobility limitations, cognitive impairment, visual/hearing impairment, or any residents needing assistance during an evacuation and must be addressed in the fire safety and evacuation plan documentation. During the interview, the AD-A and the RN-B confirmed the finding. 3. The licensee lacked a record of employee orientation training specifically on the fire safety and evacuation plan. Survey staff explained to the that the minimum required employee training is twice a year after new hire orientation for fire safety and evacuation. The facility policy (dated 2/9/2023) outlined the correct training frequency requirement, but no record of documented dates for training was provided for review to substantiate employee orientation training upon hire on fire safety and evacuation plan since resident intake on February 14, 2023. The RN-B commented that they have performed drills as training.Survey staff explained that evacuation drills were considered excercises to be ready for an emergency rather than training on fire safety and evacuation plan.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
0 810	Continued From page 19 On March 28, 2023, at approximately 1:15 p.m., during the exit interview, the AD-A and the RN-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedroom # 2 with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident bedroom #2 on the main floor. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 820	A Fire watch will be prescribed immediately and log to assess all areas affected every 1 hour. All Blessed Hands Employees are made aware of the potential fire hazards associated with their particular area of the facility and are instructed in what they can do to eliminate and/or correct hazardous conditions in the conduct of their regular	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(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
0 820	Continued From page 20 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 28, 2023, approximately from 10:50 am to 11:40 a.m., survey staff toured the home with the administrator (AD)-A. Registered nurse (RN)-B joined the tour at 11:15 a.m. At approximately 11:00 a.m., survey staff asked the AD-A to open the egress window (encasement type) in occupied resident bedroom #2 on the main floor, and survey staff measured the clear window opening in bedroom #2 with a width dimension of 16 inches and height of 48 inches. Survey staff explained to the AD-A that the window with a clear opening of 16 inches failed to meet the minimum state standard width of 20 inches for the egress window due to the obstruction of the window once the egress window is in the fully opened position. The AD-A visually verified the finding at the time of the tour. Existing bedroom egress windows must meet the minimum net clear opening of 4.5 square feet (648 square inches) with a minimum clear window opening width of 20 inches (and height of 32 inches). On March 28, 2023, at approximately 1:10 p.m., at the exit interview, survey staff explained to the AD-A and the RN-B that an immediate correction order was issued for the above finding in bedroom #2. The AD-A acknowledged the above finding and stated that they will take care of the window correction.	0 820	duties. All Blessed Hands employees are trained that a potential hazards would include smoking, space heaters, use of electrical extension cords, improper storage of combustibles, blocked exits, improper storage/use of oxygen, cooking, soiled linen storage. The Director of Nursing staff are keenly aware of what's happening and to keep a watchful eye for problems affecting patient/resident safety. Staff are not only be trained to identify hazards, but also in the procedure to follow to report them so that they can be corrected as quickly as possible. All Employees are trained and familiarized with the fire alarm and evacuation signals, their assigned duties in the event of an alarm or emergency, evacuation routes, areas of refuge (if any), exterior assembly areas and procedures for evacuation. All employees are trained to call 9-1-1 in any fire and are trained to fight fires using portable fire extinguishers and also know the locations and proper use of those extinguishers Call 9-1-1 Cottage grove Fire department: 651-458-2809 8641 80th St S, Cottage grove MN 55016. Employee assigned as fire watch shall follow the requirements listed on the Fire Watch Duties sheet and shall patrol all unprotected areas of the building every 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(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
0 820	Continued From page 21 No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820	hour to check for signs of fire or smoke conditions. All patrols are to be recorded on this Fire Watch Log Sheet immediately following each round. - identified the risks created by the impairment: Room 2 has a client with a minimum window opening meeting minimum state standard for egress. - Established a fire watch and back-up fire protection: Effective immediately, check log every 15 minutes - Mitigated ignition sources and/or shut down hazardous processes: - Expedited repairs: ASAP - Ensured that the fire protection system was properly restored to service. In Proceed Fire watch expect that all employees will receive on-going training with respect to their duties under this plan	
01620 SS=D	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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(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
01620	Continued From page 22 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 resident 14-day reassessment and monitoring was conducted, as required, for one of two residents (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included schizoaffective disorder, depressive type. R1 started receiving services from the licensee on February 28, 2023, to assist with bathing, behavior observation, and medication administration. R1's record contained an initial assessment dated	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
01620	Continued From page 23 February 23, 2023; however, an assisted living 14-day assessment was not completed on or prior to March 9, 2023. On March 28, 2023, registered nurse (RN)-B stated that the assessment had been completed but was not entered into the medical record as required. The licensee's 6.01 Assessments, Reviews and Monitoring policy, noted the initial nursing assessment or reassessment would include all of the elements of the uniform assessment tool as required. Resident reassessments and monitoring would be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessments and monitoring would be conducted as needed on changes in needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the care and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
02310	Continued From page 24	02310		

services according to the acceptable health care medical or nursing standards of one of one resident (R2) with bedrails.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R2 started receiving services from the licensee on February 14, 2023, to assist with bathing, dressing, behavior observation, medication administration, and transferring.

R2's diagnoses included, but were not limited to chronic cognitive impairment, Dementia, below left knee amputation.

The surveyor observed R2's bed had a commercially manufactured tube style upper bedrails attached to the bed and in the upright position on both sides of the resident's bed.

R2's records reviewed lacked assessment and documentation of the use of side rails including:
-Risk vs. benefits discussion individualized to each resident's risks;
-Documentation of installation, use, and maintenance according to manufacturer's guidelines;
-Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
02310	Continued From page 25	02310		

-Documentation of any necessary information related to interventions to mitigate safety risks;
-Documentation of updated bed rail assessment at least every 90 days;
-Documentation that the bed rails were determined to not act as a restraint;
-Documentation that bed rails were installed and maintained according to the manufacturer's guidelines;
-Readily accessible manufacturer's bed rail guidelines.

R2's record lacked evidence that a comprehensive bed rail assessment had been completed and an explanation of the risks and benefits of the use of the bed rail had been provided to the resident, or the resident's representative.

On March 28, 2023, registered nurse (RN)-B verified R2's bed rail had not been assessed for safety and that the licensee did not provide education to the resident or the resident's representative regarding the risks and benefits of having a bed rail.

The Food and Drug Administration (FDA), "Recommendations for Health Care Providers about Bed Rails," dated July 9, 2018, included the following information:
-Follow the health care facility's procedures and/or manufacturer's recommendations/specifications for installing and maintaining bed rails for the particular bed frame and bedside rails used.

-Inspect and regularly check the mattress and bedrails to make sure they are still installed correctly and for areas of possible entrapment and falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
02310	Continued From page 26 Regardless of mattress width, length, and/or depth, the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. -Regularly assess that bed rails remain appropriately matched to the equipment and to the patient's needs, considering all relevant risk factors. -Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. -Re-assess the person's needs and re-evaluate the equipment if an episode of entrapment or near-entrapment occurs, with or without serious injury. This should be done immediately because fatal "repeat" events can occur within minutes of the first episode. -Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or water bed. -When in doubt, call the manufacturer of the rails for assistance. The Minnesota Department of Health's Assisted Living Resources & Frequently-asked Questions: Consumer Bed Rails, dated November 29, 2022, indicated documentation about a resident's bed rails includes, but is not limited to:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
02310	Continued From page 27	02310		

-Purpose and intention of the bed rail.
-Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail.
-The resident's bed rail use/need assessment.
-Risk vs. benefits discussion (individualized to each resident's risks).
-The resident's preferences.
-Installation and use according to manufacturer's guidelines.
-Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation.
-Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.

The Minnesota Department of Health's Assisted Living Resources & Frequently-asked Questions: Consumer Bed Rails, dated November 29, 2022 further included that if a facility is unable to locate manufacturer's guidelines, the facility is unable to assess and determine if the portable bed rail is being used appropriately and installed properly, resulting in an imminent safety risk for the resident.

The licensee's Assessing the Safety of Side Rails policy, indicated the RN would evaluate whether the side rail appeared to be safe for the resident. The RN would educate the resident, the resident's representative and/or family members about the risks related to side rails. The RN would document recommended options and response from the resident, resident's family and resident's representative.

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: ______ B. WING ______	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	**8465 79TH STREET S COTTAGE GROVE, MN 55016**

(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
02310	Continued From page 28 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *03/28/23*
Time: 09:33:06
Report: 1018231057

Food and Beverage Establishment Inspection Report

Location:
Blessed Hands Health Care in C
8465 79TH STREET S
Cottage Grove, MN55016
Washington County, 82

Establishment Info:
ID #: 0041207
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR. CORRECTED ON SITE.

Corrected on Site

Food and Equipment Temperatures

Process/Item: Cold Holding/ YOGURT
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding/ BUTTER
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

INSPECTION CONDUCTED WITH JAMES LARSON (HRD) PRESENT.

PHYSICAL FACILITIES WERE OBSERVED TO BE IN GOOD CONDITION.

DISHWASHER OBSERVED TO HAVE SANITIZE FUNCTION.

ESTABLISHMENT DOES ONLY SAME DAY SERVICE OF FOODS.

SINK HAS A SEPARATE SIDE FOR HAND WASHING.

DISCUSSED EMPLOYEE ILLNESS AND ILLNESS REPORTING.

DISCUSSED PEST CONTROL MANAGEMENT.

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 1018231057 of 03/28/23.

Certified Food Protection Manager: DOMINIC IRABOR

Certification Number: FM115379 Expires: 03/02/26

Inspection report reviewed with person in charge and emailed.

Signed: ____________________

DOMINIC IRABOR
MANAGER

Signed:

Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us