STATE LICENSING COMPLIANCE REPORT

Report #: HL313361801C

Date Concluded: June 18, 2024

Name, Address, and County of Facility Investigated:
Caring Nurses LLC
7700 Shingle Creek Drive
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Zalei Lewis RN, BSN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL313361801C On March 20, 2024 through March 21, 2024 the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Comprehensive Assisted Living Facility. The following correction orders are issued that were not issued at the time of immediate correction orders. The following correction order is issued/orders are issued for #HL313361801C tag identification 0680,0790, 0800, 0810.	0 000	Assisted Living Provider 144G. 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.	

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0 680	Continued From page 1	0 680		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency disaster plan (EDP) containing all the requirements outlined in Appendix Z. This had the potential to affect 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	0 680		

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0 680	Continued From page 2 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 the potential to affect a large portion or all of the residents). The findings include: A facility incident report dated March 1, 2024, at 11:30 p.m. indicated the alarm in the house came on and staff found there was smoke all over the downstairs. 911 was called and residents were removed from the home. Staff reported that they started evacuating the residents after calling 9-1-1 and took the residents across the street. Fire service checked the home and determined the dryer. Okay to return. Per the facility incident report, no emergency contacts were called after the incident that produced smoke/fire and involved the police and fire officials. A police report indicated police were dispatched to the facility on March 1, 2024, due to a reported house fire. The police report indicated that all residents were remove from the property. Police were initially informed that there was smoke coming from the basement and that the reporting party saw flames. Upon arrival to the facility, officers noted there was a staff member at the front entrance of the door. Police asked the staff member if there were any other residents in the home. The staff member told police there were two residents in the home they were unable to move. Police then went in to check for the two residents. Police also went to the basement to see if there were any residents in the basement where the smoke and flames were seen. Police were able to see smoke in the basement of the home, however, did not see any flames. After	0 680		

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0 680	Continued From page 3 seeing that were no residents in the basement, police went back upstairs to check for more residents. Staff members told police that the residents were in one of the back rooms. The residents were able to get one of the residents onto a wheelchair and remove them from the home. Police then went to another room where another resident was, who was unable to move and had to be placed in a wheelchair. Officers placed the resident onto a wheelchair so she could be safely removed from the home. Firefighters arrived on scene at this point, and police assessed the facility. the home. Police asked staff if all of the residents that were in the home were removed from the home. Staff stated that all residents were outside of the house now and that there should be nobody else inside. Police were cleared from the scene after firefighters arrived. A complaint investigation was initiated on March 20, 2024 by an MDH investigator at approximately 2:07PM. At this time, there were two unlicensed personal (ULP) working. On March 20, 2024, at 2:34 PM, the investigator asked the ULP where the fire plan/emergency disaster plan (EDP) book or binder was located. ULP-A stated the EDP book was downstairs but unable to articulate where downstairs the binder/books were. The investigator requested for staff to locate the book and the ULP again directed the investigator downstair. The investigator told staff that they needed to locate the book/binder for the investigator to review. On March 20, 2024, at 2:48 PM the ULP were unable to locate the EDP book/binder. ULP told the investigator to call the registered nurse (RN)-C and provided the investigator with RN-C's	0 680		

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0 680	Continued From page 4 phone number and told the investigator to "Call her to answer." On March 20, 2024, at 2:52PM, ULP-A located the EDP binder. The binder entitled "Emergency Preparedness" was located, behind a padlocked pantry cupboard in the kitchen, stored among food. ULP reported to the investigator that the binder had been dropped off earlier that day, on March 20, 2024. The ULP's did not know if the binder had been dropped off by the "pharmacy man" or the "maintenace man." Review of the EDP binder indicated the binder included the fire extinguisher inspection log. The log contained three fire extinguishers (1, 2, and 3) with inspection dates of January 14, February 13, and March 13, 2024. No prior dates of inspections were documented. When the investigator asked which extinguisher was #1, #2, and #3, ULP were unable to distinguish one extinguisher from another. ULP were unable to explain why three fire extinguishers were included on the record and the number of extinguishers in the facility exceeded the number of three. ULP were also unable to verbalize where all fire extinguishers in the facility were located. During further record review on March 20, 2024, the licensee's EDP lacked the following components: -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; - An emergency disaster plan prominently posted - Building emergency exit diagrams were provided to all residents; - Emergency exit diagrams posted on each floor;	0 680		

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0 680	Continued From page 5 and -A written policy and procedure regarding missing residents. In addition, the plan did not include and the facility could not provide documentation of 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. During the investigator's onsite tour on March 20, 2024, the investigator identified that fire evacuation plans were displayed on the walls on all floors, however, the fire extinguishers were not all marked on the plans. The investigator noted that the EDP book was not accessible as it was in the food pantry with food and behand a paddlock. It took 20 minutes for ULP to find the "Emergency Preparedness" binder on March 20, 2024. When ULP were asked if they were trained in fire preparedness, they affirmed yes, however, could not recall when, and could not locate information that the investigator requested in the EDP. When ULP-A and ULP-B were asked on March 20, 2024 what they would do if a fire occured in the facility and both replied the would contact the RN-C. During interview on May 3, 2023, at 11:05 a.m., the licensed assisted living director (LALD)-C stated she was not aware there wasn't an emergency evacuation plan posted in the licensee's building or that the licensee did not have the most up to date documentation regarding the licensee's emergency plan. LALD-C thought that all staff and all residents had been educated on the licensee's emergency evacuation plan but was unaware there was no documentation showing they received the education.	0 680		

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0 680	Continued From page 6 The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will 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 would disrupt services. No further information was provided. TIME PERIOD TO CORRECT: 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, record review, and interview, the licensee failed to maintain and provide the required size of portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff.	0 790		

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0 790	Continued From page 7 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 the potential to affect a large portion or all of the residents). The findings include: On March 20, 2024 and March 21, 2024 regulator and staff toured the facility and observed the fire extinguishers on-site. 1. The portable fire extinguishers were found unmounted both in the basement and on the ground level. One fire extinguisher was found to be located on the floor of a common living space between a door and a piece of furniture During observation on March 20, 2024 at approximately 2:33 p.m., a resident in a wheelchair came close to hitting the extinguigher with the wheel of their chair. 2. The portable fire extinguishers were observed with no tags attached to indicate the required annual service and monthly inspections from this year, or any previous years. One fire extinguisher that was located in the laundry area of the facility was untagged and undated, and contained rust on the side of the extinguisher. 3. The facility "Emergency Preparedness" book was located behind a padlocked pantry cupboard in the kitchen, stored among food, a fire extinguisher inspection log was found in the binder. The binder contained three fire	0 790		

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0 790	Continued From page 8 extinguishers (1, 2, and 3) with inspection dates of January 14, February 13, and March 13, 2024. No prior dates of inspections were documented. When the regulator asked which extinguisher was #1, #2, and #3, staff was unable to distinguish one extinguisher from another. Staff were also unable to explain why three fire exinguishers were contained on the record and the number of extinguishers in the facility exceeded the number of three. Staff was unable to verbalialize where all fire extinguishers in the facility were located. 4. The facility was cited by the Minnesota Department of Health on May 2, 2023, for failure to comply with fire extinguisher tags to indicate annual service, and monthly inspection. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and	0 800		

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0 800	Continued From page 9 operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program after a fire occurred at the facility. This has the potential to directly affect the residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 21, 2024, an MDH investigator toured the home with two unlicensed personnel (ULP)-A and ULP-E. During the tour, the investigator observed and ULP-A and ULP-E verified the following: Resident room windows: -Bedroom #2-ULP were able to open windows, however a wooden rail was fastened to wood supporting the window panes and obstructed the direct ability to exit the windows when opened due to the wooden support rail structure. -Bedroom #3- ULP were unable to open the window. -Bedrom #4-ULP were unable to open the window. -Bedroom #5- ULP attempted and failed to open the large double-hung type egress windows in resident room # 5 (unoccupied) on the main level for measurement. The ULP agreed that the windows need to be repaired for immediate	0 800		

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0 800	Continued From page 10 opening and use. -Bedroom #6-ULP were unable to open the windows in the room. One window contained a glass pane that was being secured into place with the use of duct tape. This window was unable to be opened by ULP. -The storage room in the basement under the stairway had a door when opened was partially blocked with storage supplies and not properly maintained free of obstructions to allow for a proper exit from inside the room. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 800		
0 810 SS=I	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.	0 810		

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0 810	Continued From page 11 (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 observation, interview, and document review, the licensee failed to develop, maintain, and utilize a fire safety and evacuation plan with all required components following a fire that occurred at the facility. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a client's health or safety, 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 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 clients). Findings Include: On March 1, 2024, a fire was reported at the facility. Unlicensed personnel (ULP) were unable to evacuate all residents from the facility until	0 810		

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0 810	Continued From page 12 police arrived to evacuate the residents. A police report dated March 4, 2024, included on March 1, 2024, police arrived on scene and saw a staff member at the front entrance of the door. Police asked the staff member if there were any other residents in the home which he stated there were two residents in the home that they were unable to move. A facility incident report dated March 1, 2024, at 11:30 p.m. indicated the alarm in the house came on and staff found there was smoke all over the downstairs. 911 was called and residents were removed from the home. Staff reported that they started evacuating the residents after calling 9-1-1 and took the residents across the street. Fire service checked the home and determined the dryer. Okay to return. Per the facility incident report, no emergency contacts were called after the incident that produced smoke/fire and involved the police and fire officials. The police report dated March 4, 2024, indicated police were dispatched to the facility on March 1, 2024, due to a reported house fire. Police were initially informed that there was smoke coming from the basement and that the reporting party saw flames. Upon arrival to the facility, officers noted there was a staff member at the front entrance of the door. Police asked the staff member if there were any other residents in the home. The staff member told police there were two residents in the home they were unable to move. Police then went in to check for the two residents. Police also went to the basement to see if there were any residents in the basement where the smoke and flames were seen. Police were able to see smoke in the basement of the home, however, did not see any flames. After	0 810		

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(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 13 seeing that were no residents in the basement, police went back upstairs to check for more residents. Staff members told police that the residents were in one of the back rooms. The residents were able to get one of the residents onto a wheelchair and remove them from the home. Police then went to another room where another resident was, who was unable to move and had to be placed in a wheelchair. Officers placed the resident onto a wheelchair so she could be safely removed from the home. Firefighters arrived on scene at this point, and police assessed the facility. the home. Police asked staff if all of the residents that were in the home were removed from the home. Staff stated that all residents were outside of the house now and that there should be nobody else inside. Police were cleared from the scene after firefighters arrived. -On March 20, 2024, at 2:07PM, an MDH investigator initiated a complaint investigation. On March 20, 2024, at 2:34 PM, the investigator asked the ULP where the fire plan/emergency disaster plan (EDP) book or binder was located. ULP-A stated the EDP book was downstairs but unable to articulate where downstairs the binder/books were. The investigator requested for staff to locate the book and the ULP again directed the investigator downstair. The investigator told staff that they needed to locate the book/binder for the investigator to review. On March 20, 2024, at 2:48 PM the ULP were unable to locate the EDP book/binder. ULP told the investigator to call the registered nurse (RN)-C and provided the investigator with RN-C's phone number and told the investigator to "Call her to answer."	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/21/2024

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0 810	Continued From page 14 On March 20, 2024, at 2:52PM, ULP-A located the EDP binder. The binder entitled "Emergency Preparedness" was located, behind a padlocked pantry cupboard in the kitchen, stored among food. ULP reported to the investigator that the binder had been dropped off earlier that day, on March 20, 2024. The ULP's did not know if the binder had been dropped off by the "pharmacy man" or the "maintence man." The facility house manager (HM)-C was asked by the investigator who was responsible for evacuating residents in the event of another fire or emergency. HM-C responded, "The firemen?" HM-C was asked if she had been trained in fire preparedness. HM-C affirmed yes, however, could not recall when the training occurred and could not provide evidence or documentation of the training. During review of the provided Emergency Preparedness binder the investigator noted the binder did not contain all required components including the following: (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.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 15 (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. During interview on May 3, 2023, at 11:05 a.m., the licensed assisted living director (LALD)-C stated she was not aware there wasn't an emergency evacuation plan posted in the licensee's building or that the licensee did not have the most up to date documentation regarding the licensee's emergency plan. LALD-C thought that all staff and all residents had been educated on the licensee's emergency evacuation plan but was unaware there was no documentation showing they received the education. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will 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 would disrupt services. No further information was provided. TIME PERIOD TO CORRECT: Twenty-One (21) Days	0 810		