Electronically Delivered

August 16, 2022

Administrator
Mercy Housing, LLC
7601 10th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL34047015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 15, 2022, for the purpose of evaluating and 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, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the 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 resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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. 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,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34047	A. BUILDING: _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY HOUSING LLC	7601 10TH AVENUE SOUTH RICHFIELD, MN 55423

(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 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: SL34047015 On June 13, 2022, though June 15, 2022, 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 was one (1) resident who received assisted living services.	0 000	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 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 ensure the required staffing plan was developed and posted as required. This had the potential to affect one (1) resident residing in the facility, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: During the initial tour, on June 13, 2022, at 10:15 a.m., the surveyor did not observe a posted staff schedule in the main entry, or any common area of the facility developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked - identify the direct-care staff member's resident assignments or work location and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On June 15, 2022, at approximately 12:30 p.m., administrator (A)-B confirmed a staffing plan was not developed and a staffing schedule was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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:	0 480		

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0 480	Continued From page 3 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all one (1) resident residing at the facility. 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 June 13, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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0 480	Continued From page 4 (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 485		

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0 485	Continued From page 5 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 13, 2022, at 10:15 a.m., while conducting a tour of the licensed facility, the surveyor did not observe a posted menu in the kitchen, the main entry, or any common area of the facility. Unlicensed personnel (ULP)-C acknowledged the licensee did not post a menu for the resident. ULP-C stated the licensee asked at each meal what R1 would like to eat and tried to provide the requested meal. During the entrance conference on June 13, 2022, at 11:30 a.m., administrator (A)-B stated the licensee provided three meals daily and snacks as offered or requested. On June 15, 2022, at 10:35 a.m., R1 stated he did not observe a posted menu in the facility and was not aware of what the meal included until he received it. On June 15, 2022, at approximately 12:30 p.m., A-B stated the menu was to be posted in a common area at least one week in advance for the resident to observe. A-B verified the licensee did not post a menu as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 490	Continued From page 6	0 490		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 490		

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0 490	Continued From page 7	0 490		

safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On June 13, 2022, at 10:15 a.m., during a tour of the licensee, the surveyor did not observe a posted activity calendar throughout the common areas or in the resident's private room. Unlicensed personnel (ULP)-C acknowledged an activates calendar was not posted in a common area or provided to residents residing in the facility. ULP-C explained, "I ask him every day what he wants to do, and we try to do it."

On June 14, 2022, at 10:35 a.m., R1 stated the licensee did not provide activities for him or post an activity event calendar. R1 stated he preferred to "stay active." R1 further explained that he "sits around all day" and would like to "go to the library and read books."

On June 15, 2022, at 12:20 p.m., administrator (A)-B stated she expected a monthly activity calendar to be posted in a nonconscious place for residents to observe. A-B stated she expected:
- the activities to reflect the interests of the residents
-the activity calendar to have a variety of activities
-residents should be included in planning the activity calendar

Observations on June 13, 2022, through June 15, 2022, revealed the licensee did not provide or offer activities to R1 that were planned or

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0 490	Continued From page 8 unplanned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
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 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain infection control policies and procedures that complied with accepted health care, medical, and nursing standards for infection control related to the COVID-19 pandemic when the licensee failed to ensure visitors, employees, and residents were screened for COVID-19 with temperature checks and screening questions and failed to develop policies and procedures to guide decision making related to COVID-19 pandemic. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 9	0 510		

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 all four residents).

The findings include:

On June 13, 2022, at 10:00 a.m., unlicensed personnel (ULP)-C met the Minnesota Department of Health (MDH) at the front door and admitted the surveyor inside. ULP-C did not screen the MDH surveyor for COVID-19 with a temperature check and screening questions. ULP-C did not don a mask.

On June 13, 2022, at 11:00 a.m., the Public Health Sanitarian (PHS) arrived at the facility and was admitted inside the facility by ULP-C. ULP-C did not screen the PHS.

On June 13, 2022, at 11:30 a.m., administrator (A)-B arrived at the facility. A-B was not screened for COVID-19 with a temperature check and screening questions by licensee staff or independently.

On June 13, 2022, at 2:35 p.m., A-B stated the licensee:
-did not have a functioning thermometer
-did not screen staff, visitors or residents on a routine (daily) basis
-did not have a current screening log for staff, visitors, or residents and
-did not have policies to include the new Assisted Living Licensure requirements that went into effect August 1, 2021.

Policies and procedures related to infection control/COVID-19 screening was requested but

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0 510	Continued From page 10 not obtained. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.	0 550		

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0 550	Continued From page 11 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: On June 13, 2022, at 10:15 a.m., during a tour of the licensee's facility, the surveyor did not observe posted information regarding the licensee's grievance procedure, the name, the telephone number, or the e-mail contact information for the individuals who are responsible for handling resident grievances. On June 15, 2022, at 11:20 p.m., administrator (A)-B confirmed the required content noted above had not been posted in the facility as required and staff was not aware of the requirements for all the postings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 550		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34047	A. BUILDING: _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 780	Continued From page 12 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the interconnection, maintenance, and the minimum number of smoke alarms. This has the potential to directly affect resident(s), 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 June 15, 2022, between the hours of 1:00 p.m. and 2:10 p.m., survey staff toured the home	0 780		

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0 780	Continued From page 13 with the licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the following findings: MISSING SMOKE ALARMS 1) The hallway outside within the vicinity of the resident rooms on the basement level was not provided with a smoke alarm. Survey staff and the LALD-B observed the label on the back of a detector that stated the detector was a "single station alarm carbon monoxide detector". The LALD-B stated she thought the carbon monoxide detector was a smoke alarm. 2) Resident room # 3 on the lower-level floor was not provided with a smoke alarm. Survey staff and the LALD-B observed a detector was a single station alarm carbon monoxide detector consistent with the detector located outside in the hallway. The LALD-B confirmed the finding. 3) The hallway outside within the vicinity of the resident rooms on the main floor failed to sound when tested. Survey staff explained that the smoke alarm was not working properly as there was no sound. Survey staff also advised the LALD-B to verify to ensure that smoke alarms need to be replaced every 10 years from the manufactured date. The LALD-B verified the finding. INTERCONNECTION OF SMOKE ALARMS The smoke alarms failed to sound all smoke alarms as required for interconnection of all smoke alarms in the home. The smoke alarms located in resident rooms #1, #2, and #4 were tested, and all sounded local. Survey staff also explained to the LALD-B that all missing smoke alarms (Room #3 and the hallways of the bedrooms on the lower- and upper-level floors) must be interconnected with the home smoke alarm system such that when any one smoke	0 780		

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	34047	A. BUILDING: _____ B. WING _____	06/15/2022

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0 780	Continued From page 14 alarm sound, all smoke alarms sound in the home for notification. On June 15, 2022, at approximately at 2:30 p.m., the LALD-B acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
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 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	0 800		

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	34047	A. BUILDING: _____ B. WING _____	06/15/2022

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0 800	Continued From page 15 has affected or has the potential to affect a large portion or all of the residents). The findings are: On June 15, 2022, between the hours of 1:10 p.m. and 2:10 p.m., survey staff toured the home with the licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the following findings: 1) The shower spray head was missing from the pipe on the wall of the combination shower/tub fixture. The resident-1 was present and stated that it broke off. The LALD-B also added that maintenance has been called for repair. 2) The egress encasement window in resident room #2 (main floor) was not operational. Survey staff observed a missing handle for proper use to open the window for egress. In addition, survey staff also observed the exterior of the window was obstructed by large tree branches restricting the opening of the window fully for safe egress. Survey staff explained although the room currently was not occupied, the egress window must be in working order, easily operable, and be kept cleared of all obstructions for safe egress. The LALD-B searched for the missing window handle but failed to locate it. The LALD-B verified the findings. 3) The egress window wells in resident rooms #3 and #4 on the lower-level floor were enclosed by a decorative fence that was high enough to obstruct and restrict proper egress. Survey staff explained to the LALD-B that although both rooms were not currently occupied, the window well obstructions must be removed and be maintained free of all obstructions for use in case	0 800		

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0 800	Continued From page 16 of fire or emergency. 4) The sliding door to the deck on the main floor had a broken handle for proper use. On June 15, 2022, at approximately at 2:40 p.m., the LALD-B acknowledged the findings during the exit interview. No Further information was provided. TIME PERIOD FOR CORRECTION: Two (2) 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	0 810		

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0 810	Continued From page 17 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, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the required training on fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2022, at approximately 2:10 p.m., survey staff received and reviewed the home's fire safety and evacuation documentation, the evacuation drill, and the training documentation from the licensed assisted living director (LALD)-B.	0 810		

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0 810	Continued From page 18 FIRE SAFETY AND EVACUATION PLAN The plan documentation lacked fire protection procedures for residents. EVACUATION DRILLS Documentation review indicated the minimum number of drills were not performed as required. No drill records were provided for review. The LALD-B explained that she just took over in February 2022, and no drills have been performed. On June 15, 2022, at approximately 2:30 p.m., the LALD-B acknowledged the above findings at the exit interview. Survey staff advised the LALD-B to perform employee drills as required and to cover all shifts performed by employees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750		

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01750	Continued From page 19	01750		

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to have specified, in writing, specific instructions for each resident and documented those instructions in one of one resident record (R1) reviewed for medication administration delegated to unlicensed personnel.

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:

R1's diagnoses included, but were not limited to type 2 diabetes, schizophrenia and pain.

R1's Service Plan Agreement signed April 28, 2022, indicated R1 received assistance with bathing, dressing, grooming, oral hygiene, compression stockings, toileting, and medication administration.

R1's current physician orders included, but were not limited to:
-losartan 25 milligrams (mg) every day (QD)
-benztropine 2 mg two times a day (BID)
-olanzapine 20 mg QD
-citalopram 20 mg QD
-aripiprazole 20 mg QD

R1's record lacked instructions regarding when each medication was to be administered. R1's record also lacked specific written instructions

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01750	Continued From page 20 regarding the administration of as needed (PRN) medications. On June 14, 2022, at 10:25 a.m. unlicensed personnel (ULP)-C administered R1's medications. ULP-C stated although R1 refused medications frequently, ULP-C did not record refusals or update the registered nurse with each occurrence. The instructions did not give specific time or indication for medication administration. On June 15, 2022, at 12:00 p.m., administrator (A)-B confirmed there were no specific times for R1's medication administration or instructions for R1's PRN pain medication administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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

Type: Full
Date: *06/13/22*
Time: 10:00:00
Report: 8041221110

Food and Beverage Establishment Inspection Report

Location:
Mercy Housing Llc
7601 10th Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0038767
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123535464
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.

SHELL EGGS STORED ON TOP SHELF ABOVE READY-TO-EAT FOODS IN THE REFRIGERATOR. EGGS WERE MOVED TO THE BOTTOM SHELF IN REFRIGERATOR DURING INSPECTION.

Comply By: 06/13/22

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

ESTABLISHMENT IS WASHING, THEN RINSING DISHES IN THE TWO BASIN SINK WITH NO SANITIZE STEP. USE THE DISH MACHINE FOR DISH WASHING. VERIFY THAT THE TEMPERATURE FOR SANITIZING IS AT LEAST 160 DEG F.

Comply By: 06/13/22

4-300 Equipment Numbers and Capacities

4-302.12A ** Priority 2 **

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO FOOD THERMOMETER ON SITE.

Comply By: 06/20/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

NO IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR FOR MEASURING THE UTENSIL SURFACE (HOT WATER) TEMPERATURE FOR THE DISH MACHINE. THERMAL LABELS PROVIDED DURING INSPECTION TO TEST DISH MACHINE.

Comply By: 06/27/22

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

OBSERVED EMPLOYEE RINSE DISHES IN THE HANDWASHING SINK.

Comply By: 06/13/22

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER. STAFF IS SCHEDULED TO TAKE A FOOD SFAETY CLASS THIS MONTH. APPLICATION AND INFORMATION EMAILED TO ESTABLISHMENT.

Comply By: 06/13/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETER LOCATED IN THE REFRIGERATOR.

Comply By: 06/20/22

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: refrigerator: milk
Violation Issued: No

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

Inspection was completed with Najma Hassan (staff on duty). Mary Bruess was the lead RN with HRD completing the site survey. This inspection report was also reviewed with the RN for this facility, Faduma Mohamad, by phone.

This is a residential house with kitchen equipment that is not ANSI certified. Food may be prepared for

same-day service only. There is currently only one resident on site (4 person maximum).

Discussed the following:
Employee illness policy and logging requirements
Handwashing
Glove-use and bare hand contact
Date marking
Proper food storage
Violations on this report

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 8041221110 of 06/13/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Najma Hassan
Staff on Duty

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us