



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 7, 2024

Licensee
New Life Care LLC
4913 Winchester Lane North
Brooklyn Center, MN 55429

RE: Project Number(s) SL37013015

Dear Licensee:

On May 13, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 16, 2024, 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,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 8, 2024

Licensee

New Life Care, LLC

4913 Winchester Lane North

Brooklyn Center, MN 55429

RE: Project Number(s) SL37013015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 16, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.31, Subd. 4 (a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

MDH may impose 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. MDH

An equal opportunity employer.

Letter ID: IS7N REVISED

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 (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 survey:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, reading "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/16/2024
NAME OF PROVIDER OR SUPPLIER NEW LIFE CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) 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: SL37013015-0 On February 13, 2024, through February 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents: all of whom received services under the Assisted Living license. An immediate correction order was identified on February 13, 2023, issued for SL37013015-0, tag identification 0820. On February 15, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. 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). These findings include: On February 13, 2024, at 7:56 a.m., the surveyor observed the Board of Executives for Long-Term Services and Supports (BELTSS) website which indicated licensed assisted living director (LALD)-C held a current assisted living director license, however, was not listed as the director of record for the licensee. On January 18, 2024, at 10:30 a.m., LALD-C stated when they registered on BELTSS, they did not enlist as the director of record, and they will function as the director of record until they can delegate that role.	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 The licensee's 4.01 Assisted Living Director policy dated November 9, 2021, read, "1. New Life Care expects the licensed or permitted Director to comply with all requirements set forth by BELTSS as a licensed professional to remain in good standing (i.e., notifications, education requirements, renewal, etc.)." No further information was received. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees;	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records	0 250			

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0 250	Continued From page 4 reviewed. 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: During the entrance conference on February 26, 2024, at 9:38 a.m., licensed assisted living director (LALD)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-C on December 23, 2023. The licensee had an assisted living license issued on January 1, 2023, with an expiration date of December 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or	0 250			

Minnesota Department of Health

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0 250	Continued From page 7 implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - reminders for medications, treatments, or exercises, if provided; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - medication and treatment management. On February 16, 2024, at 11:12 a.m., LALD-C confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0110, 0470, 0480, 0510, 0630, 0660, 0680, 0790, 0800, 0810, 0820, 0950, 0970, 1290, 1500, 1620, 1640, 1730, 1760, 1890, 2290, and 2320 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.	0 250			

Minnesota Department of Health

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0 250	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
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 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:	0 470			

Minnesota Department of Health

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0 470	Continued From page 9 Based on interview and record review, the licensee failed to develop and implement a staffing plan for determining its staffing level that included an evaluation completed by a registered nurse (RN) at least twice a year (as indicated in Minnesota Administrative Rule 4659.0180). 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 February 13, 2024, at 1:00 p.m., the surveyor did not observe the staffing plan. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated it was something in RTasks (software documenting program), and the RN was responsible for the staffing plan. On February 13, 2024, at 1:59 p.m., RN-B stated they are new to the position with the licensee, and the plan should be created by the director of the facility. The licensee failed to provide a staffing plan that was reviewed twice yearly. The licensee's 4.06 Staffing & Scheduling policy dated November 09, 2021, read, "The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate	0 470			

Minnesota Department of Health

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0 470	Continued From page 10 number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. 2. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract b. Each resident's acuity level, as determined by the most recent assessment or individualized review c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises d. Whether the facility has a secured dementia care unit, and e. Staff experience, training, and competency." No further information was provided. TIME PERIOD FOR 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 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	0 480			

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0 480	Continued From page 11 Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 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.	0 510			

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0 510	Continued From page 12 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 that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of two unlicensed personnel ((ULP)-A). 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 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). On February 13, 2024, at 11:30 a.m., the surveyor observed ULP-A in the kitchen of the facility. Without completing hand hygiene or putting on clean gloves, ULP-A prepared food for residents within the facility. ULP-A was then observed leaving the kitchen to put on gloves. The surveyor observed ULP-A put on clean gloves without completing hand hygiene. ULP-A finished preparing food, and was observed removing gloves at 11:35 a.m. No hand hygiene was observed upon removal of gloves. On February 14, 2024, at 7:02 a.m., the surveyor observed ULP-A in the dining area apply gloves, walk downstairs to the medication cabinet and remove a resident's medication bin. ULP-A returned upstairs to the dining table. ULP-A prepared medications for a resident and gave the medication cup to the resident. ULP-A removed gloves then used a laptop computer to chart in	0 510			

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0 510	Continued From page 13 RTasks (a documenting software) without performing hand hygiene. On February 14, 2024, at 7:18 a.m., the surveyor inquired about hand hygiene after glove removal. ULP-A stated they did not recall being trianed on hand hygiene after gloves were removed. Hand hygiene training was completed under nursing supervision. On February 14, 2024, at 7:21 a.m., licensed assisted living direcotr (LALD)-C stated the RN trained staff on hand hygiene practices. On February 14, 2024, at 7:28 a.m., clinical nurse supervisor (CNS)-B stated staff are trained to wash hands before medication administration to a resident and to wash hands before and after gloves are removed. The licensee's 8.07 Gloves policy dated September 11, 2021, indicated staff should perform hand hygiene before and after gloves are removed. The Centers for Disease Control's (CDC), "Hand Hygiene Guideance" dated January 20, 2022 reads: 1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body	0 510			

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0 510	Continued From page 14 site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 630			

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0 630	Continued From page 15 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 was admitted to the licensee for assisted living services August 26, 2023. R1's diagnosis included anxiety, schizophrenia, and bipolar disorder. R1's unsigned Service Plan dated October 29, 2023, indicated R1 received services including bathing needs, housekeeping, medication administration, medication management, and behavior management. R1's Individual Abuse Prevention Plan, dated December 9, 2023, indicated R1 was at risk of being abused by others however, lacked an individualized abuse prevention plan to include: - the person's risk of abusing other vulnerable adults, and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On February 14, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-B confirmed that R1's IAPP lacked the required content. CNS-B stated some IAPPs were developed by a prior RN, but that this would be their responsibility to complete in the future, and the task would be included in future assessments for residents. The licensee's 6.05 Individual Abuse Prevention Plan policy, dated November 29, 2021, indicated	0 630			

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0 630	Continued From page 16 the following: "The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: - other vulnerable adults - the person's risk of abusing other vulnerable adults, and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 660			

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0 660	Continued From page 17 licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). 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 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 February 14, 2024, at 10:22 a.m., licensed assisted living director (LALD) -C provided documentation of a Tuberculosis (TB) Risk Assessment, dated June 23, 2022, which indicated the facility was a low risk. LALD-C stated that this was the facilities most current and up to date TB risk assessment. LALD-C stated that they were unaware that this was an annual requirement. On February 14, 2023, at approximately 1:00 p.m., clinical nurse supervisor (CNS)-B stated that he was unaware that the facility was required to complete and annual TB risk assessment and asked the surveyor where they may find the assessment tool. The surveyor assisted CNS-B by directing them to the Minnesota department of health (MDH) website to retrieve the assessment tool. The licensee's 8.16 Tuberculosis Screening	0 660			

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0 660	Continued From page 18 policy dated November 9, 2021, indicated that the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "each provider licensed by MDH is required to complete a TB risk assessment annually. Completion of this assessment will assist providers in the development of an infection control committee and in determining the frequency of screening." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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	0 680			

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0 680	Continued From page 19 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 interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined 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, 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 February 4, 2024, at 8:23 a.m., the surveyor retrieved the licensee's Emergency preparedness plan binder from the licensed assisted living director (LALD)-C. LALD-C retrieved the emergency preparedness plan (EPP) binder from a lockable desk drawer. LALD-C stated that the document was complete in its required contents and was normally stored in the basement of the facility in the LALD's desk.	0 680			

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0 680	Continued From page 20 On February 16, 2024, at approximately 11:50 a.m., during the exit conference, LALD-C stated that they had thought that their EPP was complete in its content and lacked deficiencies. The licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - Annual review of the Emergency Preparedness Plan; - EPP contained a blank signature page intended for sign off on annual reviews; - Quarterly review of missing resident policy; - EPP did not contain a quarterly review of the missing resident policy as required by Minnesota Rules 4659.0110, Subp. 4; - A written risk assessment utilizing an all-hazards approach; - EPP contained a blank template; - Policies and procedures to identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - EPP contained a partially completed template for succession planning and delegation of authority; - Annual review and/or updates of policies; - Policies and procedures for tracking staff and patients; - Roles under wavier declared by secretary; - Policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver; - Development of Communication Plan; - EPP contained a partially completed template; - Names and contact information of staff, entities providing services under agreement, residents physicians, other facilities, and volunteers; - EPP contained a partially completed	0 680			

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0 680	Continued From page 21 template; - Policies and procedures including primary and alternate means of communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies; - EPP contained a partially completed template which lacked alternate means of communication; The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated November 9, 2021, indicated the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790			

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0 790	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 13, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-C. It was observed that the portable fire extinguishers throughout the facility lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. During interview on February 15, 2024, at 1:30 p.m., survey staff explained to LALD-C that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the	0 790			

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0 790	Continued From page 23 extinguisher that would prevent their operation when needed. LALD-C verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=D	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, 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 800			

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0 800	Continued From page 24 The findings include: On February 13, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-C. It was observed that the window well in bedroom #5 had trees starting to grow in it that were obstructing the operation of the egress window. Window wells must be cleaned out and well maintained to allow for the proper function of the egress window. It was observed that the floor tile in the dining room had areas where the tile was not secured to the subfloor and would wiggle when stepped on. During interview on February 15, 2024, at 1:30 p.m. LALD-C acknowledged the window well needed to be maintained, but stated they were unaware of the loose tile in the dining room. LALD-C stated they would get the items corrected. TIME PERIOD FOR CORRECTION: Seven (7) 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,	0 810			

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0 810	Continued From page 25 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 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 record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly 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 potential to affect a large portion or all of	0 810			

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0 810	Continued From page 26 the residents). The findings include: On February 13, 2024, licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "9.06 Fire Policy", dated 11/09/2021, and FSEP titled "Fire Safety", dated 8/01/2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar	0 810			

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0 810	Continued From page 27 emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on February 15, 2024, at 1:30 p.m., LALD-C stated they had not had an opportunity to update the policy to make it site specific. The policies reviewed were unedited policies purchased from third-party providers that were not specific to the facility. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-C was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-C was unable to provide documentation showing any training provided or training scheduled for a future date for staff on the fire safety and evacuation plan. During an interview on February 15, 2024, at 1:30 p.m., LALD-C stated they understood the requirements and would implement a training program that was compliant with statute requirements DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill	0 810			

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0 810	Continued From page 28 every other month. LALD-C was unable to provide documentation showing any evacuation drills completed since licensure. During an interview on February 15, 2024, at 1:30 p.m., LALD-C stated they had completed two evacuation drills, but did not have any documentation of them. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=H	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 bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors.	0 820			

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0 820	Continued From page 29 This practice resulted in a level three violation (a violation that harmed a resident'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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 13, 2024, from 1:00 p.m. to 2:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-C. During the tour, survey staff asked LALD-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Occupied Sleeping Rooms: Bedroom #1 occupied by R1: three (3) windows, the largest window measuring 18 inches clear width, 39.5 inches clear height, and 711 square inches total open area per window. Bedroom #2 occupied by R2: two (2) window measuring 29 inches clear width, 16 inches clear height, and 464 square inches total open area. The windows in bedrooms #1 and #2 did not meet the minimum requirements for opening height and the windows in bedromm #2 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.	0 820			

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0 820	Continued From page 30 Survey staff explained to LALD-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD-C verbally confirmed the findings. On February 13, 2024, survey staff explained to LALD-C that an immediate correction order was issued for the above finding. LALD-C acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate. On February 15, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 820			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and	0 950			

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0 950	Continued From page 31 advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included language within the residency agreement contract which limited the rights of all residents residing within 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 of the residents). Findings include: On February 13, 2024, at 11:38 a.m., after completion of the entrance conference the surveyor requested additional information from licensed assisted living director (LALD)-C including the facilities admission packet and blank contract.	0 950			

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0 950	Continued From page 32 The admission packet provided to the surveyor lacked the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On February 14, 2024, at 10:38 a.m., LALD-C provided an admission packet. Within the admission packet was a blank copy of the blank contract. LALD-C stated that this is the same contract and admission packet that is used for all residents. On February 14, 2024, at 1:30 p.m., LALD-C stated that at the time of admission, if a resident wishes to identify a designated representative, they may do so at the time of signing of the contract on page one and twelve of the contract. LALD-C stated that they were unaware that the contract lacked the verbatim language required by statute. The licensee's 1.08 Designated Representative policy, dated November 9, 2021, indicated the following: 1. Prior to, or at the time of execution of an assisted living contract New Life Care staff will discuss with the resident the Designated Representative form.	0 950			

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0 950	Continued From page 33 2. If the resident has a formal declaration for another person to be the designated representative, staff may help the resident fill out the Designated Representative form. 3. The Designated Representative form must provide the following verbatim notice: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	0 970			

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0 970	Continued From page 34 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Assisted Living Contract included the following section which contained language waving the licensee's liability for health, safety, or personal property of a resident: "Damage of injury to Resident of Resident's Property. We are not responsible for any damage or injury suffered by you, your property, your guests or their property that was not caused by us. We strongly recommend that Resident obtain renter's insurance at an appropriate level to insure against loss of Resident's personal property, as well as related incidental and consequential damages, or such other or additional insurance as Resident considers necessary to protect against injuries and property damage. Our insurance may not cover the loss of your personal property and the incidental and consequential damages arising from the loss of such property. Your personal property includes but is not limited to dentures, glasses and hearing aids."	0 970			

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0 970	Continued From page 35 On February 14, 2024, at 10:38 a.m., licensed assisted living director (LALD)-C stated the contract with this language was used for all residents. On February 13, 2024, at 12:58 p.m., LALD-C stated they have property insurance, and has never asked a resident for money for damage to the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a	01290			

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01290	Continued From page 36 background study was submitted and a clearance received in affiliation with the licensee's current health facility identification (HFID) for four of four employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-A, ULP-E, ULP-F). 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: ULP-A ULP-A was hired on July 20, 2022, to provide assisted living services. ULP-A's employee record included a background study dated July 20, 2022, from an inactive comprehensive home care licensure, under the same ownership umbrella, with a health facility identification number (HFID) # 35418. ULP-A's employee record lacked evidence to indicate the licensee had submitted a background study under the licensee's current assisted living license and affiliated to the licensee's HFID # 37013 prior to the start of survey. On February 13, 2024, at 11:30 a.m., the surveyor observed ULP-A providing assisted living services to residents residing within the facility. CNS-B CNS-B was hired on January 20, 2020, and	01290			

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01290	Continued From page 37 started to provide direct care services. CNS-B employee file included a background study clearance dated January 9, 2020, from an inactive comprehensive home care licensure, under the same ownership umbrella, with HFID # 35418. CNS-B held an active registered nurse license with an issue date of July 30, 2009, and an expiration date of July 31, 2024. CNS-B's employee record lacked evidence to indicate the licensee had submitted a background study under the licensee's current assisted living license and affiliated to the licensee's HFID # 37013 prior to the start of survey. On February 14, 2024, at 9:39 a.m., CNS-B arrived at the facility and was observed working on a laptop computer at the dining table. ULP-E ULP-E was hired May 13, 2023, to provide assisted living services. ULP-E's employee record included a background study dated May 4, 2023, from an inactive comprehensive home care licensure, under the same ownership umbrella, with HFID # 35418. ULP-E's employee record lacked evidence to indicate the licensee had submitted a background study under the licensee's current assisted living license and affiliated to the licensee's HFID # 37013 prior to the start of survey. ULP-F ULP-F was hired November 10, 2022, to provide assisted living services.	01290			

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01290	Continued From page 38 ULP-F's employee record included a background study dated November 10, 2022, from an inactive comprehensive home care licensure, under the same ownership umbrella, with HFID # 35418. ULP-F's employee record lacked evidence to indicate the licensee had submitted a background study under the licensee's current assisted living license and affiliated to the licensee's HFID # 37013 prior to the start of survey. On February 14, 2024, at 9:11 a.m., LALD-C stated the licensee used to operate under a comprehensive license, HFID # 35418, and they believed everyone was "grandfathered in". LALD-C stated they are one company but are now separate. The licensee's 4.02 Background Studies dated November 9, 2021, indicated will conduct background checks on all employees, volunteers, and contractors at (licensee name). No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of	01500			

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01500	Continued From page 39 vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased	01500			

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01500	Continued From page 40 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-A 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: ULP-A was hired on July 20, 2022, to provide direct care services to residents. On February 14, 2024, at 8:00 a.m., ULP-A's employee file lacked evidence of the required annual training. The employee transcript indicated the following required education was not completed: - Reporting maltreatment of vulnerable adults or minors;	01500			

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01500	Continued From page 41 - Assisted Living Bill of Rights; - Infection control techniques; -Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - Review of provider's policies and procedures; -Principles of person-centered planning/service delivery and; -Dementia Training: Met two (2) hours annually. On February 14, 2024, at 9:05 a.m., LALD-C stated this was ULP-A's up-to date employee training. The licensee's 5.06 Annual Required Staff Training 5.06 dated November 9, 2021, indicates all direct care staff will complete at least eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
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	01620			

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01620	Continued From page 42 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 90 calendar days from the initiation of services for one of two residents (R4). 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). R4 R4 admitted to the licensee on July 19, 2022, and began receiving assisted living services. R4's diagnosis include anxiety and depression. R4's Resident Profile dated November 8, 2022,	01620			

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01620	Continued From page 43 indicated R4 received assistance with bathing reminder, dressing, laundry, manage behavior, meal reminder, vital signs (VS), and socialization. R4's medical record included Nurse Assessment dated January 18, 2023, the next 90 day assessment should have been completed by April 19, 2023. The surveyor observed in RTask (software documenting program) the next Nurse Assessment was dated May 5, 2023. The assessment was 17 days late. On February 13, 2024, at 1:56 p.m., the surveyor inquired about assessment timeframes. clinical nurse supervisor (CNS)-B stated resident assessments were done every 90 days unless there is a change of condition or hospitalization. On February 14, 2024, at 10:33 a.m., CNS-B stated they were unsure why the assessment was late and was missed by the previous nurse. The licensees 6.01 Assessments, Reviews & Monitoring dated November 9, 2021, indicated nurse assessments should not exceed 90 days between each assessment date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640			

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01640	Continued From page 44 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of two residents (R1, R4). 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 widespread 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).	01640			

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01640	Continued From page 45 The findings include: R1 R1 was admitted on August 22, 2023, and began receiving assisted living services. R1's diagnosis included anxiety, schizophrenia, bipolar disorder, diabetes, and post-traumatic stress disorder. R1's record contained an unsigned Service Plan (Waiver) - Addendum to contract which was dated October 29, 2023. The service plan indicated R1 received assistance with housekeeping, behavior management, meal assistance, medication administration, medication setup, and transportation assistance. This document lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services. R4 R4 admitted to the licensee on July 19, 2022, and began receiving assisted living services. R4 diagnosis include anxiety and depression. R4's Resident Profile dated November 8, 2022, indicated R4 received assistance with bathing reminder, dressing, laundry, manage behavior, meal reminder, vital signs (VS), and socialization. R4's unsigned Service Plan (Waiver) -Addendum to Contract dated October 29, 2023, lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services. The service plan also lacked a list of services the licensee would	01640			

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01640	Continued From page 46 provide to the resident. On February 14, 2024, at 12:31 p.m., clinical nurse supervisor (CNS)-B stated service plans should be completed when a resident is admitted or if there is an update or assessment, and should be signed by the resident, RN, and licensee. CNS-B stated the signature might not be done for the residents. The licensee's 6.08 Service Plan dated November 9, 2021, indicated residents will have a service plan in place, and will include a signature or other authentication by (licensee name) and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of	01730			

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01730	Continued From page 47 diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of three residents (R1). 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	01730			

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01730	Continued From page 48 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 R1 was admitted on August 22, 2023, and began receiving assisted living services. R1's diagnosis included anxiety, schizophrenia, bipolar disorder, diabetes, and post-traumatic stress disorder. R1's record contained an unsigned Service Plan (Waiver) - Addendum to contract which was initiated on October 29, 2023. The service plan indicated R1 received assistance with housekeeping, behavior management, meal assistance, medication administration, medication setup, and transportation assistance. R1's Individual Medication Management Plan dated December 9, 2023, lacked the following required contents: - a description of medication storage based on residents needs; and - a person responsible for monitoring medication supplies and refills. On February 14, 2024, at 12:34 p.m., clinical nurse supervisor (CNS)-B stated that they were aware that resident medication management plans required descriptions of medication storage and a person to be identified as the individual responsible for monitoring supplies and refills. CNS-B stated they had not completed R1's	01730			

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01730	Continued From page 49 medication management plan, and that the previous registered nurse (RN) had completed it. In addition, CNS-B was able to open the previous assessment form on R1 to demonstrate where the requirement had been overlooked. The licensee's 7.03 Medication Management Individualized Plan dated November 9, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain a description of storage based on the resident's needs and identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for one of three residents (R1).	01890			

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01890	Continued From page 50 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: On February 13, 2024, at 12:06 p.m., the surveyor conducted a review of the licensee's locked medication cabinet. The medication cabinet contained all medications administered to residents and was in the basement of the facility. Resident specific medications were separated into separate plastic bins. The surveyor observed the following unlabeled time sensitive medications: - R1's Breo Ellipta 200 mcg/25 mcg inhaler. The manufacturer's instructions printed on the back of the medication packaging indicated that the medication must be discarded 6 weeks after opening the tray or when the counter reads "0". On February 14, 2024, at approximately 1:00 p.m., clinical nurse supervisor (CNS)-B stated that they were responsible for maintenance of the medication cabinet and would routinely go through the cabinet on a weekly basis to audit medications and to remove expired medications. CNS-B stated that they were aware that this medication had not been dated upon opening but did not feel comfortable putting an opened-on label as they did not know when the medication was opened.	01890			

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01890	Continued From page 51 The licensee's undated and un-customized 7.11 Medication Storage policy indicated that medications will be stored consistent with manufacturer's recommendations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included language within the residency agreement contract which limited the rights of all residents residing within 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 of the residents). Findings include: On February 13, 2024, at 11:38 a.m., after completion of the entrance conference the	02290			

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02290	Continued From page 52 surveyor requested additional information from licensed assisted living director (LALD)-C including the facilities admission packet and blank contract. On February 14, 2024, 10:34 a.m., LALD-C stated that all residents are required to sign house rules upon admission and that house rules are used to ensure the safety of the house. On February 14, 2024, at 10:38 a.m., licensed assisted living director provided an admission packet. Within the admission packet was a blank copy of the blank contract. Page 15 of the provided contract was the facility house rules. LALD-C stated that this is the same contract and admission packet that is used for all residents. The provided blank Resident Contract for Assisted Living included the following language on page eight, under the section titled Resident Policies, Rules, and Regulations: "By signing the Agreement, you agree to abide by and comply with all of the Community's policies, rules and regulations which have been provided to you. The Community reserves the right to adopt, amend and discontinue policies, rules, and regulations. The Community will provide you with written notice of all such changes. The rules and regulations are attached." On page 15 of the blank contract under the section titled "New Life Care House Rules", Line 23 indicated the following: "Repeated violations of these rules would cause termination of this Resident Contract." Licensee's form titled New Life Care House Rules	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/16/2024
NAME OF PROVIDER OR SUPPLIER NEW LIFE CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02290	Continued From page 53 included the following language which limited the rights of residents: - Absolutely no alcohol, no drugs, and no drug paraphernalia are permitted in the house; - All prescription medications shall be turned over to the staff for safe keeping and proper administration; - Staff reserve the right to perform a room search at any time it is deemed necessary to ensure the safety and security of everyone; - No firearms, hunting knives or other weapons are permitted; - No type of financial transaction is allowed; - House curfew is 10:30 p.m. every night. Doors will be locked at 11:00 p.m. unless approved by staff; - Residents are allowed to have visitors, but the visitor must leave before 10:00 p.m.; - Visitation: Due to the number of residents that are in the house and the size of the house: a. Residents must notify staff prior to the visit; b. One visitor at a time, and two or three visitations per week; c. The client is responsible for their visitor, and visitors must sign in; d. Visitors are not permitted into the house if they are under the drug or alcohol influence; e. Staff have the right to ask the visitor to leave if necessary; and - Eating in the room is not allowed, except for some snacks. On February 14, 2024, at 1:47 p.m., LALD-C stated that the house rules were developed due to previous residents that displayed disruptive behaviors and are intended to aid in protecting other residents residing within the facility. LALD-C stated that they were not aware that the facilities house rules had the potential to violate a resident's rights and would look for other	02290			

Minnesota Department of Health

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02290	Continued From page 54 solutions outside of implementing house rules to provide redirection for residents displaying disruptive behaviors in the future. The licensee's 1.07 Bill of Rights policy dated November 9, 2021, indicated that the rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed follow appropriate medication administration procedures for one of two residents (R1). 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	02320			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NEW LIFE CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429			
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02320	Continued From page 55 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated 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: R4 R4 admitted to the licensee on July 19, 2022, and began receiving assisted living services. R4 diagnosis include anxiety and depression. R4's Resident Profile dated November 8, 2022, indicated R4 received assistance with bathing reminder, dressing, laundry, manage behavior, meal reminder, vital signs (VS), and socialization. R4s undated Scheduled Medications document indicated R4 was to be administered Lo-Zummandimi 3-0.02 milligram (mg) daily, omeprazole 20 mg daily, sertraline 100 mg daily, sertraline 25 mg and hydroxyzine hydrochloride 25 mg as needed (PRN). On February 14, 2024, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-A unlock a metal cabinet located on the lower level of the house, removed a blue bin with R4's name and relock the cabinet. ULP-A walked upstairs to the dining table where R4 was sitting. From a medication container, ULP-A placed the following medications into a medication cup: Lo-Zummandimi 3-0.02 mg, omeprazole 20 mg, sertraline 100 mg. ULP-A handed R4 the medication cup to R4 and R4 swallowed the medications. ULP-A removed gloves and did not perform hand hygiene. ULP-A then opened the	02320			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NEW LIFE CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429		
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02320	Continued From page 56 laptop computer and opened RTasks (software documenting program). ULP-A marked; setup, verify and administered for Lo-Zummandimi 3-0.02 mg, omeprazole 20 mg, sertraline 100 mg, then marked the complete button. ULP-A did not check the electronic medication administration record (EMAR) prior to the medication administration. On February 14, 2024, at 7:12 a.m., ULP-A stated they were trained how to administer medications by the registered nurse (RN). When the medications are in a bubble pack, they should verify the name and make sure it's the right medication, "med errors are dangerous." ULP-A stated they verified medications to administer by the content of the resident medication bin. On February 14, 2024, at 7:19 a.m., licensed assisted living director (LALD)-C stated the RN, the house manager, and LALD trained staff. LALD-C stated that they were notified of any errors right away, they have been through the training many times with staff. LALD-C stated medications should be verified before administered to a resident. On February 14, 2024, at 7:29 a.m., clinical nurse supervisor (CNS)-B stated staff are trained to follow the five or six rights of medication administration and to verify medication list before residents were given medications. The six rights of medicaiton are: - right patient; - right medication; - right dose; - right time; - rigth route and; - right documentation	02320			

Minnesota Department of Health

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02320	Continued From page 57 The licensee's undated 7.27 PRN Medication & Treatment indicates staff are to review the resident's medication sheet at the time of administering medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



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

Type: Full
Date: 02/13/24
Time: 19:21:09
Report: 1050241019

Food and Beverage Establishment Inspection Report

Page 1

Location:

New Life Care Llc
4913 Winchester Lane North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038426
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632577118
ID #:

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

The following orders were issued during this inspection.

2-500 Responding to contamination events

2-501.11

**** Priority 2 ****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

FACILITY DOES NOT CURRENTLY HAVE A VOMIT CLEAN UP KIT ONSITE. COMPLY WITH RULE ABOVE. FACT SHEETS PROVIDED VIA EMAIL WITH CARD FOR FOLLOW-UP.

Comply By: 02/13/24

2-100 Supervision

2-102.12AMN

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

FACILITY CURRENTLY DOES NOT HAVE A CFPM ON SITE. MR. ABDUSALAM IS IN THE PROCESS OF RE CERTIFYING. INSTRUCTIONS WILL BE SUPPLIED VIA EMAIL. COMPLY WITH RULE ABOVE.

Comply By: 02/13/24

Food and Equipment Temperatures

Process/Item: Cold Holding/Milk

Temperature: 40.8F Degrees Fahrenheit - Location: Kitchen Refrigerator

Violation Issued: No

Process/Item: Cold Holding/ Lettuce

Temperature: 38F Degrees Fahrenheit - Location: Kitchen Refrigerator

Violation Issued: No

Type: Full
Date: 02/13/24
Time: 19:21:09
Report: 1050241019
New Life Care Llc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding/ Cheese

Temperature: 39F Degrees Fahrenheit - Location: Kitchen Refrigerator

Violation Issued: No

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

Inspection was completed with the owner Mr. Abdusalam Facility had two residents on site at time of inspection. Meals are prepared on site. This establishment has a residential kitchen. The kitchen has wood cabinets with a hollow base and wood flooring. All found to be in good condition. A two basin sink is located in the kitchen with discussed the use of a third basin designated for handwashing. Current dish machine is currently not in use facility only uses paper plates and plastic utensils.

Discussed the following:

- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Food storage and preventing cross contamination
- Date marking
- Vomit clean up procedures
- Restrictions concerning serving a highly susceptible population

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 1050241019 of 02/13/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: _____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us