Electronically Delivered

December 28, 2022

Licensee
Agape Assisted Living And Housing Services, Inc.
3450 20th Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL39389015

Dear Licensee:

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

The Minnesota Department of Health completed a initial evaluation on December 12, 2022, for the purpose of assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

authorized in § 144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required = $500

The total amount you are assessed is $500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state licensing order under Minn. Stat. § 144G.91 Subd. 8), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

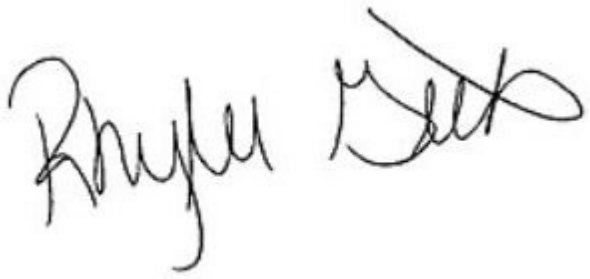
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 218-232-8285 Fax: 651-281-9796

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39389	A. BUILDING: _____ B. WING _____	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE ASSISTED LIVING AND HOUSING SER	3450 20TH AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39389015 On December 5, 2022 through December 12, 2022 the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were two residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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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 of the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 5, 2022, at 8:45 a.m., during the provisional assisted living facility (PALF) entrance conference, licensed assisted living director (LALD)-A identified herself as the LALD for the facility. LALD-A obtained an assisted living director license on September 16, 2021. On December 5, 2022, the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-A held a current assisted living director license. The BELTSS website did not indicate LALD-A as the Director of Record for	0 110		

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0 110	Continued From page 2 the licensee. On December 5, 2022, at 4:30 p.m., LALD-A verified she was not listed as the Director of Record for the licensee. LALD-A stated she was not aware of the requirement for the Director of Record and stated she would contact BELTSS to update. A policy regarding listing the LALD as the director of record was requested but not provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 470		

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0 470	Continued From page 3 facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan to determine staffing levels to meet the needs of residents. This had the potential to affect all of the licensee's 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 December 5, 2022, at 8:45 a.m., during the provisional assisted living facility (PALF) entrance conference, licensed assisted living director (LALD)-A, who was also the registered nurse, and owner (OW)-C, both stated the usual staffing schedule for the facility was as follows: - LALD-A was at the facility 51 hours every two weeks and was also on-call. - the day shift was staffed with one unlicensed personnel (ULP) from 8:00 a.m. to 4:00 p.m.; - the evening shift was staffed with one ULP from	0 470		

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0 470	Continued From page 4 4:00 p.m. to 12:00 a.m.; and - the night shift was staffed with one ULP from 12:00 a.m. to 8:00 a.m. On December 5, 2022, at 3:53 p.m., LALD-A stated the licensee did not have a developed written staffing plan. The licensee's policy titled "Staffing and Scheduling," dated October 28, 2022, indicated the nurse would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 12, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, and other guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must respond promptly to the grievances and	0 530		

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0 530	Continued From page 6 recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a process to include designating a staff person to be responsible for providing assistance and responding to resident council recommendations and grievances. This had the potential to affect all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 5, 2022, at 8:45 a.m., during the provisional assisted living facility (PALF) entrance conference, licensed assisted living director (LALD)-A and owner (OW)-C, both stated they had not established a resident council. The licensee's policy titled "Resident and Family Councils," dated February 1, 2022, indicated the licensee would provide residents and families the opportunity, space, and privacy for meetings, as reasonably achievable.	0 530		

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0 530	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 530		
0 540 SS=C	144G.41 Subd. 6 Family councils The facility must provide a family council with space and privacy for meetings, where doing so is reasonably achievable. The facility must designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the family council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the family council, take reasonably achievable steps to make residents and family members aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a process to include designating a staff person to be responsible for providing assistance and responding to family council recommendations and grievances. This had the potential to affect all of the licensee's residents and their families. This practice resulted in a level one violation (a violation that has not 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 the	0 540		

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0 540	Continued From page 8 residents). The findings include: On December 5, 2022, at 8:45 a.m., during the provisional assisted living facility (PALF) entrance conference, licensed assisted living director (LALD)-A and owner (OW)-C, both stated they had not established family council meetings. The licensee's policy titled "Resident and Family Councils," dated February 1, 2022, indicated the licensee would provide residents and families the opportunity, space, and privacy for meetings, as reasonably achievable. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 540		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 580		

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0 580	Continued From page 9 licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all of the licensee's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 5, 2022, at 8:45 a.m., during the provisional assisted living facility (PALF) entrance conference, licensed assisted living director (LALD)-A and owner (OW)-C, both stated they have not implemented a quality management program. On December 5, 2022, at 3:53 p.m., LALD-A stated the licensee did not have a quality management plan or any documented quality management activities. The licensee's policy titled "Quality Management Project," dated February 2, 2022, indicated the licensee would at all times have at least one documented quality management project in place, and retained records of such projects. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

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0 640	Continued From page 10 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's 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: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the	0 640		

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AGAPE ASSISTED LIVING AND HOUSING SER	3450 20TH AVENUE SOUTH MINNEAPOLIS, MN 55407

(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
0 640	Continued From page 11 assisted living facility. During the initial tour of the facility on December 5, 2022, at 10:00 a.m., the surveyor observed the main floor, upstairs and downstairs within the facility. There was no posting of the 911 emergency number, as required. On December 5, 2022, at 10:09 a.m., licensed assisted living director (LALD)-A confirmed the required content noted above was not posted. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=C	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and	0 650		

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0 650	Continued From page 12 (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee records contained the required content for one of one employee (unlicensed personnel (ULP)-B) reviewed. This deficient practice affected all the other employees. This practice resulted in a level one violation (a violation that has not 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 the residents). The findings include: The licensee's Provisional Assisted Living Facility (PALF) license became effective October 28, 2022. On December 5, 2022, at 8:45 a.m., during the PALF entrance conference, licensed assisted living director (LALD)-A and owner (OW)-C, both stated all the licensee's current staff and admitted residents were from a different licensee that was no longer in operation. LALD-A and OW-C stated	0 650		

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0 650	Continued From page 13 they continued to provide care to residents from previous licensee with the staff from previous licensee. LALD-A and OW-C both stated they received their PALF license on October 28, 2022. The licensee's staff roster included the following listed staff with employee start dates: LALD-A started employment on March 29, 2021. ULP-B started employment on March 29, 2021. OW-C started employment on January 3, 2022. ULP-D started employment on July 19, 2022. ULP-E started employment on January 19, 2022. ULP-F started employment on August 24, 2017. ULP-G started employment on January 19, 2022. ULP-B ULP-B started employment on March 29, 2021. On December 5, 2022, at 11:25 a.m., the surveyor observed ULP-B administer R1's oral medications. ULP-B's record lacked documented evidence of the following required content after the licensee received a PALF license effective October 28, 2022: - records of orientation, required training, infection control training, and competency evaluations On December 5, 2022, at 3:37 p.m., LALD-A stated ULP-B and all other licensee employee records were transferred from the previous licensee and were used as employee records under the PALF license that went into effect October 28, 2022. The licensee's policy titled "Employee Records," dated February 1, 2022, indicated the licensee would keep records up-to-date with all training, in-service education, and competency testing.	0 650		

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0 650	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a facility TB risk assessment and ensure history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of one of employee (unlicensed personnel (ULP)-B) with employee records reviewed. This had the potential to affect all of the licensee's	0 660		

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0 660	Continued From page 15 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: The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." On December 5, 2022, at 8:45 a.m., during the provisional assisted living facility (PALF) entrance conference, licensed assisted living director (LALD)-A stated she had not completed a facility TB risk assessment. ULP-B ULP-B started employment on March 29, 2021. On December 5, 2022, at 11:25 a.m., the	0 660		

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0 660	Continued From page 16 surveyor observed ULP-B administer R1's oral medications. ULP-B's employee records lacked evidence of baseline TB history and symptom screening or of being screened for active TB with either a two-step TST or serum blood test. On December 5, 2022, at 4:08 p.m., LALD-A verified she had not completed a TB risk assessment. LALD-A verified documentation of ULP-B's required TB history and symptom screening was not in ULP-B's employee record. LALD-A stated the licensee did not require two-step TST tests on employees, the licensee required an IGRA blood test. LALD-A stated ULP-B did not have record of an IGRA blood test. The licensee's policy titled "Tuberculosis Screening," dated October 28, 2022, indicated the licensee would establish and maintain a comprehensive TB infection control program based on the most current guidelines issued by the Center for Disease Control and Prevention (CDC). The policy indicated there would be completion of a written community TB risk assessment. The same policy indicated there would be screening of staff for active TB, and staff would have an IGRA blood test or a two-step Mantoux conducted. Record would be kept in the employees file. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 17 (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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and failed to post an EPP prominently. This had the potential to affect all of the licensee's 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	0 680		

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0 680	Continued From page 18 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 December 5, 2022, at 10:00 a.m., a facility tour was conducted with the licensed assisted living director (LALD)-A. In the common area on the main floor, there was two cork boards with multiple required postings. However, there was no EPP posted. During an interview on December 5, 2022, at 11:36 a.m., LALD-A verified there was no EPP signage posted on the cork boards. On December 5, 2022, at 2:22 p.m., the licensee's EPP was reviewed with owner (OW)-C. During the review OW-C verified the following policies and procedures were missing from the EPP. The licensee's EPP did not include the following content: - a description of the population served by the licensee to identify at risk populations - process for emergency preparedness (EP) cooperation and collaboration with state and local EP officials/organizations - policies and procedures based the EP, risk assessment and communication plan - the development of policies and procedures to address: - policy and procedure for system to track the location of on-duty staff and sheltered residents - policy and procedure to address, system of documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records	0 680		

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0 680	Continued From page 19 - policy and procedure that addresses the use of volunteers, including the process/role for integration - no 1135 waiver, policy and procedure for providing care/treatment at alternate sites -no written communication plan, which must include names/contact information of staff, entities providing services, resident's physicians, other facilities, and volunteers - the communication plan must include contact information for the following: federal, state, tribal, regional, and local EP staff, state licensing and certification agency, MN Office of Ombudsman for long term care, and other sources of assistance - the communication plan must also include a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care - the communication plan must also include sharing occupancy/needs. A means to provide information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction The licensee's policy titled "Disaster Planning and Emergency Preparedness," dated February 1, 2022, indicated the licensee's EPP will comply with Centers for Medicare and Medicaid Services (CMS) appendix Z. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 20 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 21 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included the required content for one of one resident (R1) resident with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's Provisional Assisted Living Facility (PALF) license became effective October 28, 2022. On December 5, 2022, at 8:45 a.m., during the PALF entrance conference, licensed assisted living director (LALD)-A and owner (OW)-C, both stated all the licensee's current staff and admitted residents were from a different licensee that was no longer in operation. LALD-A and OW-C stated they continued to provide care to residents from previous licensee with the staff from previous licensee. LALD-A and OW-C both stated they received their PALF license on October 28, 2022.	0 730		

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0 730	Continued From page 22 R1's diagnoses included type II diabetes and hypertension. R1's service plan dated for August 15, 2022. R1's Individual Abuse Prevention Assessment and Plan dated for August 15, 2022. R1's care plan dated for August 15, 2022. R1's fall risk assessment dated for September 15, 2022. On December 5, 2022, at 1:00 p.m., LALD-A verified the licensee used R1's assessments, care plan, and service plan from the previous licensee that was no longer in operation. LALD-A stated she had not updated all of R1's records after the PALF license went into effect on October 28, 2022. The licensee policy titled "Resident Record-Information and Content," dated October 28, 2022, indicated the licensee would maintain appropriate and accurate records for each resident receiving assisted living services. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
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	0 790		

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0 790	Continued From page 23 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility fire extinguishers. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on December 07, 2022 between 11:00 AM and 11:45 PM, survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, staff observed that fire extinguishers were not being inspected monthly. LALD-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		

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0 810	Continued From page 24	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to 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 interview and record review, the licensee failed to provide the required fire safety	0 810		

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0 810	Continued From page 25 training for residents and staff, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). On December, 07 2022 between 11:00 AM to 11:45 AM, the licensed assisted living director (LALD)-A failed to provide the following documents for review: 1. The licensee failed to provide employee training logs for fire safety and evacuation. 2. The licensee failed to provide resident training logs for fire safety and evacuation. 3. The licensee failed to provide documentation showing that the required fire drills were being conducted. The LALD-A verbally confirmed survey staff observations during the record review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations	01460		

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	39389	A. BUILDING: _____ B. WING _____	12/12/2022

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01460	Continued From page 26	01460		

before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided for one of one employee (unlicensed personnel (ULP)-B) and all the other employees with records reviewed. This had the potential to affect all of the licensee's residents.

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

The licensee's Provisional Assisted Living Facility license became effective October 28, 2022.

On December 5, 2022, at 8:45 a.m., during the PALF entrance conference, licensed assisted living director (LALD)-A and owner (OW)-C, both stated all the licensee's current staff and admitted residents were from a different licensee that was no longer in operation. LALD-A and OW-C stated they continued to provide care to residents from

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01460	Continued From page 27 previous licensee with the staff from previous licensee. LALD-A and OW-C both stated they received their PALF license on October 28, 2022. The licensee's staff roster included the following listed staff with employee start dates: LALD-A with a start date of March 29, 2021. ULP-B started employment on March 29, 2021. OW-C started employment on January 3, 2022. ULP-D started employment on July 19, 2022. ULP-E started employment on January 19, 2022 ULP-F started employment on August 24, 2017. ULP-G started employment on January 19, 2022. ULP-B ULP-B started employment on March 29, 2021. On December 5, 2022, at 11:25 a.m., the surveyor observed ULP-B administer R1's oral medications. ULP-B's employee record indicated ULP-B received orientation to Home Care in accordance with 144A.4796 statutes. ULP-B's employee record lacked evidence the employee completed orientation to assisting living facility requirements in accordance with 144G statutes prior to providing direct care to residents after the PALF license went into effect on October 28, 2022, to include: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - review of the assisted living bill of rights. - principles of person-centered planning/service delivery;	01460		

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01460	Continued From page 28 - handling of resident complaints; - consumer advocacy services; - review of the type of assisted living services the employee would provide On December 5, 2022, at 3:37 p.m., LALD-A stated ULP-B and all the licensee's employee orientation training was completed and transferred from the previous licensee. LALD-A stated ULP-B and all the other licensee's employees did not receive new orientation training after the licensee received the PALF license on October 28, 2022. The licensee's policy titled "Orientation of Staff and Supervisors and Content," dated October 28, 2022, indicated all staff would complete orientation to Assisted Living licensing requirements and regulations before provided assisted living services. The same policy indicated orientation was not transferable from another provider. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

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01620	Continued From page 29 individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment to include all areas identified on the uniform assessment tool for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1's medical record was reviewed. R1's diagnoses included type II diabetes and hypertension.	01620		

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01620	Continued From page 30 R1's service plan dated August 15, 2022, indicated R1 required assistance with medication administration. R1's RN Annual Evaluation Assessment dated November 8, 2022, indicated R1 was alert, oriented to person, place, and time. R1's RN Annual Evaluation Assessment dated November 8, 2022, did not indicate the following areas reassessed using the uniform assessment tool to include: -the resident's personal lifestyle preferences -pain -emotional and mental health conditions included symptoms and effective medication treatment and non-medication interventions. -nutritional and hydration status and preferences -list of treatments, including type, frequency, and level of assistance needed -nursing needs, including potential to receive nursing-delegated services -risk indicators -decision-making authority for the resident On December 5, 2022, at 2:27 p.m., licensed assisted living director (LALD)-A, who was also the RN, stated the licensee did not have a uniform assessment tool when she conducted R1's assessment on November 8, 2022. LALD-A verified R1's assessment had missing content and areas not assessed. The licensee's policy titled "Assessments, Reviews and Monitoring," dated February 2, 2022, indicated the nursing assessment would include all elements of the uniform assessment tool. TIME PERIOD FOR CORRECTION: Seven (7)	01620		

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01620	Continued From page 31 days	01620		
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 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.	01730		

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01730	Continued From page 32 (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 plan for each resident to include all required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 5, 2022, at 8:45 a.m., during the provisional assisted living facility (PALF) entrance conference, licensed assisted living director (LALD)-A , who was also the registered nurse (RN), confirmed the licensee provided medication management services to residents at the facility. R1 R1's medical record was reviewed. R1's diagnoses included type II diabetes and hypertension.	01730		

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01730	Continued From page 33 R1's service plan dated August 15, 2022, indicated R1 required assistance with medication administration. R1's RN Annual Evaluation Assessment dated November 8, 2022, indicated R1 was alert, oriented to person, place, and time. R1's Medication Assessment and Management Plan dated November 8, 2022, indicated R1 was deemed unable to safely self administer or store medications. On December 5, 2022, at 11:25 a.m., the surveyor observed unlicensed personnel (ULP-B) administer R1's oral medications. During the same observation ULP-B stated she did not administer R1's diclofenac (topical medication to treat pain)1% gel because R1 self-administered the medication and kept it in her room. On December 5, 2022, at 11:55 a.m., R1's diclofenac 1% gel was observed on the nightstand. R1 stated she kept her diclofenac 1% gel in her room and self-administered. R1's medication administration record (MAR) dated December 5, 2022, indicated ULP-B signed off R1's diclofenac 1% gel as administered. On December 5, 2022, at 2:27 p.m., LALD-A verified R1 was assessed and deemed unable to self-administer or store the diclofenac1% gel. LALD-A stated R1 should not have had the medication in her room to self-administer. When asked if R1 received the diclofenac 1% gel as the MAR was signed off by licensee staff as administered, LALD-A stated she did not know. The licensee-provided policy titled "Medication	01730		

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01730	Continued From page 34 Management Individualized Plan," dated February 1, 2022, indicated the licensee would develop and maintain a current individualized medication management record for each resident and the record would contain the following: -documentation of specific resident instructions relating to the administration of medications. -any resident-specific requirements relating to documenting medication administration, verifications all medications administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred	01830		

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01830	Continued From page 35 only occasionally). The findings include: The licensee's Provisional Assisted Living Facility license became effective October 28, 2022. On December 5, 2022, at 8:45 a.m., during the PALF entrance conference, licensed assisted living director (LALD)-A, who was also the registered nurse (RN), and owner (OW)-C, both stated all the licensee's current staff and admitted residents were from a different licensee that was no longer in operation. LALD-A and OW-C stated they continued to provide care to residents from previous licensee with the staff from previous licensee. LALD-A and OW-C both stated they received their PALF license on October 28, 2022. R1 R1's medical record was reviewed. R1's diagnoses included type II diabetes and hypertension. R1's service plan dated August 15, 2022, indicated R1 required assistance with medication administration. R1's RN Annual Evaluation Assessment dated November 8, 2022, indicated R1 was alert, oriented to person, place, and time. R1's Medication Assessment and Management Plan dated November 8, 2022, indicated licensee staff administered R1's medications. R1's medication administration record (MAR) dated December 1 through 5, 2022, indicated the following medications were administered by licensee staff:	01830		

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01830	Continued From page 36	01830		

-atorvastatin calcium (treats high cholesterol) 20 milligrams (mg) twice daily
-baclofen (treats muscle spasms) 10 mg once daily
-diazepam (treats anxiety) 5 mg twice daily
-diclofenac (topical medication to treat pain) 1% gel 2 grams topically four times daily
-fluticasone propionate (treats nasal congestion) 50 mcg/act nasal spray once daily
-gabapentin (control seizures, treats nerve pain) 800 mg three times daily
-lisinopril (treats high blood pressure) 10 mg once daily
-metformin HCL ER (controls high blood sugars) 1000 mg twice daily
-pepcid (treats ulcers) 20 mg twice daily
-sertraline (treats depression) 200 mg once daily
-singulair (prevents asthma symptoms) 10 mg once daily
-spiriva inhaler (treats lung diseases) 18 micrograms (mcg) 1 capsule once daily
-wellbutrin SR (treats depression) 100 mg once daily
-zyprexa (treats agitation) 7.5 mg once daily

R1's prescribers orders dated November 8, 2021, indicated orders for Voltaren (diclofenac) gel 1%.

On December 5, 2022, at 2:27 p.m., LALD-A stated R1's medication prescriber orders were from November 8, 2021, and were from the previous licensee. LALD-A stated R1's prescriber orders needed renewal.

The licensee's policy titled "Medication and Treatment Orders-Renewal," dated February 1, 2022, indicated orders would be renewed at least every 12 months.

TIME PERIOD FOR CORRECTION: Seven (7)

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01830	Continued From page 37 days	01830		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 5, 2022, at 8:45 a.m., during the provisional assisted living facility (PALF) entrance conference, licensed assisted living director(LALD)-A, who was also the registered nurse (RN), confirmed the licensee provided blood glucose level checks to residents at the	01970		

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01970	Continued From page 38 facility. R1 R1's medical record was reviewed. R1's diagnoses included type II diabetes R1's medication administration record (MAR) indicated R1 received blood glucose level checks twice daily. On December 5, 2022, at 2:53 p.m., LALD-A stated the licensee did not have treatment orders available for R1's blood glucose levels check. The licensee's policy titled "Medication and Treatment Orders-Receiving," dated February 2, 2022, indicated the licensee would obtain treatment orders. The same policy indicated orders for treatments must be dated and signed by the prescriber and must be current and consistent with the nursing assessment. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Type: Full
Date: *12/12/22*
Time: 11:21:38
Report: 8058221246

Food and Beverage Establishment Inspection Report

Location:
Agape Assisted Living and Hous
3450 20th Avenue S
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0040973
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs
3-302.11A(1) ** Priority 1 **
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
RAW CHICKEN STORED WITH READY TO EAT ITEMS - COS
Comply By: 12/05/22

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CFPM
Comply By: 01/31/23

6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11
MN Rule 4626.1515 Maintain the physical facilities in good repair.
CABINET DRAWERS HAVE LOOSENED AND IMPEDED USE - REPAIR OR REPLACE
Comply By: 01/31/23

Food and Equipment Temperatures

Process/Item: TOMATO
Temperature: 39 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Type: Full
Date: *12/12/22*
Time: 11:21:38
Report: 8058221246
Agape Assisted Living and Hous

Food and Beverage Establishment Inspection Report

Process/Item: ORANGE
Temperature: 36 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTION

2 RESIDENTS, 3 BEDS AVAILABLE

RESIDENTIAL HOME IN RESIDENTIAL NEIGHBORHOOD WITH NON COMMERCIAL KITCHEN FINISHES AND APPLIANCES

HRD INSPECTOR: ANGELA VATALARO
EST. REP: LACHANDRA GUMS

NOTE
UNABLE TO ENTER REPORT BACKDATED TO A DATE PRIOR TO ENTRY INTO ACES DATABASE.

ACTUAL DATE OF INSPECTION IS 12/5/22

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 8058221246 of 12/12/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed:_____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us