



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 10, 2024

Licensee
Caring Angels
9130 Louisiana Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL38746015

Dear Licensee:

On July 2, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 19, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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

AH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 22, 2024

Licensee
Caring Angels
9130 Louisiana Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL38746015

Dear Licensee:

On April 2, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 19, 2023. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the July 19, 2023 survey.

Also, at the time of this follow-up survey completed on April 2, 2024, we identified the following violation(s):

0830-Local Laws Apply-144g.45 Subd. 3

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this of your facility.**

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.

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.

A state correction 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.

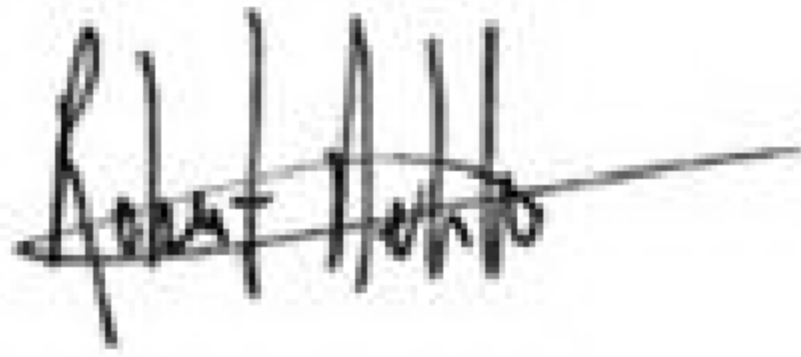
To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Bob Dehler at 651-201-3710.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Robert Dehler", with a long horizontal stroke extending to the right.

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/02/2024
NAME OF PROVIDER OR SUPPLIER CARING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445			
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL38746015-4 On March 26, 2024 through April 3, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 28, 2023. At the time of the survey, there were 2 residents; 2 receiving services under the Assisted Living license. As a result of the revisit, the following order was issued.	{0 000}			
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required 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: No further action needed.	{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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{0 470}	Continued From page 1	{0 470}			
{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: No further action needed.	{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	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 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: No further action needed.	{0 480}			
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action needed.	{0 490}			
{0 495} SS=F	144G.41 Subd. 1 (14) Minimum Requirements	{0 495}			

Minnesota Department of Health

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{0 495}	Continued From page 3 (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: No further action needed.	{0 495}			
{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: No further action needed.	{0 580}			
{0 650} SS=F	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;	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 4 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	{0 680}			

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{0 680}	Continued From page 5 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: No further action needed.	{0 680}			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on record review, the licensee failed to submit a plan review application for a facility remodeling project. 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 the potential to affect a large portion or all of the residents). Findings include:	0 830			

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0 830	Continued From page 6 On March 26, 2024, at 9:00 a.m. and March 27, 2024, at 12:56 p.m. survey staff emailed the licensee requesting an update on a room in the basement labeled as a lounge but observed to be a resident bedroom at the revisit completed on December 28, 2023. On April 2, 2024, at 10:02 a.m., the licensee emailed survey staff the following: The basement bedroom that was occupied by a resident is under construction to be built and most likely will be done within this week. The resident moved to room number 4. On April 3, 2024, at 7:57 a.m. survey staff emailed the licensee requesting a description of the basement remodeling project. On April 3, 2024, at 11:07 p.m., the licensee emailed survey staff the following: We are planning to add one more room in the basement and it's taking a little bit longer to finish this project due to financial constraints. We will keep you posted and send you the updated new floor plan once we get it done. On April 4, 2024, survey staff verified a MDH Engineering plan review application had not been submitted for the assisted living facility remodeling project based on a review of pending plan review applications in the database. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors	{01460}			

Minnesota Department of Health

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{01460}	Continued From page 7 All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations 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: No further action needed.	{01460}			
{01610} SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: No further action needed.	{01610}			

Minnesota Department of Health

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{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of 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: No further action needed.	{01620}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 1, 2024

Licensee

Caring Angels

9130 Louisiana Avenue North

Brooklyn Park, MN 55445

RE: Project Number(s) SL38746015

Dear Licensee:

On December 29, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 19, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 19, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 19, 2023, found not corrected at the time of the December 29, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) = \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 29, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$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.

IMPOSITION OF FINES:

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.

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.

A state correction 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.

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.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna". The signature is fluid and cursive, with the first name "Tim" and last name "Hanna" clearly distinguishable.

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

PMB

Minnesota Department of Health

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{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required 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	{0 110}			

Minnesota Department of Health

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

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(X6) DATE

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{0 110}	Continued From page 1 by: No further action needed.	{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 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: No further action needed.	{0 470}			

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{0 480}	Continued From page 2	{0 480}			
{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: No further action needed.	{0 480}			
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by:	{0 490}			

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{0 490}	Continued From page 3 No further action needed.	{0 490}			
{0 495} SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: No further action needed.	{0 495}			
{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: No further action needed.	{0 580}			
{0 650} SS=F	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	{0 650}			

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{0 650}	Continued From page 4 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	{0 680}			

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{0 680}	Continued From page 5 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{0 680}			
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	{0 780}			

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{0 780}	Continued From page 6 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms in the dwelling unit that complied with fire protection requirements. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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). Findings include: On December 28, 2023, at 1:55 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed when the smoke alarm outside bedroom 4 was tested by ULP-B, it activated the smoke alarm in bedroom 4, but did not activate any of the other smoke alarms installed in the building. During the facility tour interview, ULP-B verified that only some of the smoke alarms were interconnected. ULP-B stated the smoke alarms installed in bedroom 4 and outside bedroom 4	{0 780}			

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{0 780}	Continued From page 7	{0 780}			
	were new wireless smoke alarms and none of the other smoke alarms had been replaced.				
{0 790} SS=E	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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). Findings include:	{0 790}			

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{0 790}	Continued From page 8 On December 28, 2023, at 1:55 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed the following: 1. The tags attached to the portable fire extinguishers located in the kitchen and living room indicated annual maintenance had been performed by certified service personnel in April 2022. Annual maintenance had not been performed by certified service personnel in the last year. During the facility tour interview, ULP-B stated annual maintenance was scheduled for next week. 2. The monthly fire extinguisher inspection record on the back of the tag was blank for the fire extinguisher installed in the living room. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, ULP-B verified this monthly fire extinguisher inspection had not been completed.	{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	{0 800}			

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{0 800}	Continued From page 9 by: Based on observation and interview, the licensee failed to maintain the physical environment 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) 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). Findings include: On December 28, 2023, at 1:55 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed the following: 1. Door knobs were not installed on bedroom doors for rooms 1 and 3. Door hardware must be provided on bedroom doors that allow the occupant to exit through the required door in the event of an emergency. a. In occupied resident bedroom 1, the door knob had been replaced with a deadbolt lock operated by using a thumb turn or keypad. A small knob, operated by pulling or pushing, was installed on the door above the keypad. The knob was difficult to grip due to the small size and the knob was also noted as loose. The ULP-B explained this knob was installed on the door to help the resident open and close the bedroom door. b. In unoccupied resident bedroom 3, the door knob had been replaced with a deadbolt lock	{0 800}			

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{0 800}	Continued From page 10 operated by using a thumb turn or keypad. No additional door hardware was installed. Without door knobs, these bedroom doors required the deadbolt to be engaged to keep these bedroom doors shut. The ULP-B verified door knobs were not installed on the doors for bedrooms 1 and 3.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	{0 810}			

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{0 810}	Continued From page 11 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide the required training. 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 the potential to affect a large portion or all of the residents). Findings include: On December 28, 2023, at 1:55 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed a room in the basement furnished as a bedroom. During the tour interview, ULP-B confirmed the basement bedroom was occupied by a resident. The posted floor plan identified this room as a lounge. The location and number of resident sleeping rooms were not accurately identified in the fire safety and evacuation plan. On December 28, 2023, at 2:15 p.m., survey staff requested fire safety and evacuation plan (FSEP) procedures, employee and resident training records for fire safety and evacuation, and evacuation drill records from ULP-B. ULP-B	{0 810}			

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{0 810}	Continued From page 12 provided FSEP procedures. FIRE SAFETY AND EVACUATION PLAN Procedures for a fire were provided and included standard employee actions but failed to provide specific employee procedures to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions in the procedure for fire were limited to the acronyms RACE (Remove, Alarm, Confine, and Extinguish or Evacuate), and PASS (Pull, Aim, Squeeze, Sweep), calling 911, and removing residents from danger. The procedures inappropriately instruct the building occupants to generally plan to shelter in place and that the fire department will give orders on whether or not to evacuate. No protection procedures necessary for residents were included in the FSEP. No procedures were included in the FSEP identifying unique or unusual resident needs for movement or evacuation. During an interview on December 28, 2023, at 2:25 p.m., ULP-B stated they would inform the licensee that the FSEP required revision. TRAINING During an interview on December 28, 2023, at 2:25 p.m., ULP-B verified training records were not available and stated these records would be emailed by the service coordinator. On December 28, 2023, at 6:58 p.m., the licensee emailed the following documentation for review: 1. An Emergency Preparedness document 3. Three EduCare training certificates 4. The current resident roster 5. Fire drill records 6. Completed evacuation planning tools for three residents Record review indicated that the licensee failed to provide training to employees on the fire safety	{0 810}			

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{0 810}	Continued From page 13 and evacuation plans upon hire and at least twice per year thereafter, as evident by the lack of training documentation. Two certificates for employees from EduCare on emergency preparedness training were provided, dated November 10, 2023, and November 11, 2023. No employee training records supporting that training had been completed on the facility FSEP were provided. Record review indicated that the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. No resident training records were provided.	{0 810}			
{01460} SS=D	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 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: No further action needed.	{01460}			
{01610} SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a	{01610}			

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{01610}	Continued From page 14 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: No further action needed.	{01610}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of 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.	{01620}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01620}	Continued From page 15 (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: No further action needed.	{01620}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 19, 2023

Licensee
Caring Angels
9130 Louisiana Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL38746015

Dear Licensee:

On December 7, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 19, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 19, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 19, 2023, found not corrected at the time of the December 7, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) = \$500.00

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) = \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on December 7, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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.

Also, at the time of this follow-up survey completed on December 7, 2023, we identified the following violation(s):

0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2)-(3)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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.

IMPOSITION OF FINES:

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.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

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

PMB

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL38746015-2 On December 7, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 9, 2023. At the time of the survey, there were 3 residents: 3 receiving services under the Provisional Assisted Living license. As a result of the revisit, the following orders were reissued. An immediate correction order was identified on December 7, 2023, issued for SL38746015-2, tag identification 0820. On December 7, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G.	{0 000}			

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	{0 110}			
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required 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: No further action needed.	{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 facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	{0 470}			

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{0 470}	Continued From page 2 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action needed.	{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: No further action needed.	{0 480}			
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and	{0 490}			

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{0 490}	Continued From page 3 recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action needed.	{0 490}			
{0 495} SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: No further action needed.	{0 495}			
{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: No further action needed.	{0 580}			

Minnesota Department of Health

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{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	{0 680}			

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{0 680}	Continued From page 5 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{0 680}			
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 6 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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). Findings include: On December 7, 2023, at 12:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that the smoke alarm installed outside bedroom 4 did not provide an audible alarm when the smoke alarm in bedroom 4 was tested by	{0 780}			

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{0 780}	Continued From page 7	{0 780}			
	ULP-B. The smoke alarm outside bedroom 4 was not interconnected with the other smoke alarms in the dwelling unit.				
	This deficient condition was verified by ULP-B accompanying on the facility tour.				
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790			
	(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;				
	(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and				
	This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors.				
	This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all				

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0 790	Continued From page 8 of the residents). Findings include: On December 7, 2023, at 12:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the tour, survey staff observed the following: 1. The tags attached to the portable fire extinguishers showed that annual maintenance had been performed by certified service personnel in April 2022. Annual maintenance had not been performed by certified service personnel in the last year. 2. One monthly inspection was recorded on the back of the tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. During an interview with survey staff on December 7, 2023, after the tour, ULP-B verified the fire extinguishers had not been properly maintained and explained that they did not know annual maintenance and monthly inspections had not been completed as required. 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	{0 800}			

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{0 800}	Continued From page 9 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) 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). Findings include: On December 7, 2023, at 12:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed the following: 1. In occupied resident bedroom 1, the door knob had been replaced with a deadbolt lock that was operated using a thumb turn or keypad. A small knob, that was operated by pulling or pushing, had been installed on the door above the keypad. The knob was difficult to grip due to the small size and the knob was also noted as loose. The ULP-B explained that this knob was installed on	{0 800}			

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{0 800}	Continued From page 10 the door to help the resident open and close the bedroom door. 2. In unoccupied resident bedroom 3, the door knob had been replaced with a deadbolt lock that was operated using a thumb turn or keypad. No additional door hardware was installed. Without door knobs, these bedroom doors required that the deadbolt be engaged in order to keep these bedroom doors shut. The ULP-B confirmed that door knobs were not installed on the doors for bedrooms 1 and 3 and verified this deficient condition. Door hardware must be provided on bedroom doors that allow the occupant to exit through the required door in the event of an emergency. This deficient condition was verified by ULP-B accompanying on the facility tour.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	{0 810}			

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{0 810}	Continued From page 11 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, record review, and interview, the licensee failed to develop fire safety and evacuation plans with the required content, make the plans readily available, 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 the potential to affect a large portion or all of the residents). Findings include: On December 7, 2023, at 12:30 p.m., survey staff	{0 810}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CARING ANGELS			STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445		
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{0 810}	Continued From page 12 toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that a room in the basement was furnished as a bedroom. The floor plans identify this room as a lounge. The location and number of resident sleeping rooms were not accurately identified in the fire safety and evacuation plans. On December 7, 2023, after the facility tour, survey staff requested the fire safety and evacuation plans, employee and resident training records for fire safety and evacuation, and evacuation drill records from ULP-B. ULP-B explained that this documentation was not available and called the service coordinator. Survey staff requested the fire safety and evacuation plans, employee and resident training records for fire safety and evacuation, and evacuation drill records from the service coordinator/unlicensed personnel (SC/ULP)-A. The SC/ULP-A explained that the director was out of the country and they would email this information to survey staff. The SC/ULP-A confirmed that the fire safety and evacuation plans were not readily available onsite at the facility. On December 7, 2023, at 4:05 p.m., the SC/ULP-A emailed the following documentation for review: 1. Disaster Plan for Caring Angels 2. An Emergency Preparedness document FIRE SAFETY AND EVACUATION PLANS The disaster plan 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 employee actions in the disaster plan for fire were limited to	{0 810}			

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{0 810}	Continued From page 13 the acronyms RACE and PASS, calling 911, and removing residents from danger. No specific employee actions were included in the plan. The disaster plan directs the building occupants to generally plan to shelter in place and that the fire department will give orders on whether or not to evacuate. No protection procedures necessary for residents were included in the disaster plan. No procedures were included in the plan identifying unique or unusual resident needs for movement or evacuation. No fire safety and evacuation plans were included in the emergency preparedness document. TRAINING Record review indicated that the licensee failed to provide training to employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter, as evident by the lack of training documentation. No employee training records were provided. Record review indicated that the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. No resident training records were provided. EVACUATION DRILLS Record review indicated that the licensee failed to conduct employee evacuation drills twice per year per shift with at least one evacuation drill every other month as evident by the lack of evacuation drill documentation. No evacuation or fire drill logs were provided.	{0 810}			

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{0 820}	Continued From page 14	{0 820}			
{0 820} SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide an egress window that met the minimum width opening requirement in an occupied resident bedroom. This had the potential to directly affect one resident and all staff. 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 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). On December 7, 2023, at 12:30 p.m., survey staff toured the facility with unlicensed personnel	{0 820}			

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{0 820}	Continued From page 15 (ULP)-B. During the facility tour, survey staff observed that the clear openable width of the egress window measured 19.25 inches in bedroom 4, which was occupied by a resident. The egress windows did not meet the minimum width opening requirement for resident egress of 20 inches minimum. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet). This deficient condition was verified by ULP-B accompanying on the facility tour. ULP-B explained that they thought since the city approved the egress window, that MDH would accept the size of this egress window as being compliant. On December 7, 2023, after the facility tour, survey staff requested the current resident roster, ULP-B stated that they did not have a copy. ULP-B called the service coordinator. Survey staff requested the current resident roster from the service coordinator/unlicensed personnel (SC/ULP)-A. On December 7, 2023, at 4:05 p.m., the SC/ULP-A emailed wo copies of a discharged or deceased resident roster for state evaluations, a cuurent resident roster was not provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	{0 820}			
{01460} SS=D	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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{01460}	Continued From page 16 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: No further action needed.	{01460}			
{01610} SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: No further action needed.	{01610}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}			

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{01620}	Continued From page 17 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of 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: No further action needed.	{01620}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 1, 2023

Licensee
Caring Angels
9130 Louisiana Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL38746015

Dear Licensee:

On October 9, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 19, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 19, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 19, 2023, found not corrected at the time of the October 9, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on October 9, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$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.

IMPOSITION OF FINES:

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.

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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna". The signature is fluid and cursive, with a long horizontal stroke at the end.

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

PMB

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL38746015-1 On October 9, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed between July 17, 2023, and July 19, 2023. At the time of the survey, there were two (2) active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}			
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required 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:	{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 No further action needed.	{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 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: No further action needed.	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}			

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{0 480}	Continued From page 2 (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: No further action needed.	{0 480}			
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action needed.	{0 490}			

Minnesota Department of Health

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{0 495}	Continued From page 3	{0 495}			
{0 495} SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: No further action needed.	{0 495}			
{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: No further action needed.	{0 580}			
{0 650} SS=F	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,	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 4 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 5 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{0 680}			
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	{0 780}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/09/2023
NAME OF PROVIDER OR SUPPLIER CARING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445			
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{0 780}	Continued From page 6 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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 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). Findings include: On October 9, 2023, between 4:50 p.m. and 5:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that the newly installed smoke alarm outside sleeping rooms 4 and 5 did not provide an audible alarm when the smoke alarm in bedroom 4 was tested by ULP-B. The newly installed smoke alarm was not interconnected with the other smoke alarms in the dwelling unit. This deficient condition was verified by ULP-B accompanying on the facility tour.	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	{0 780}			
{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) 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). Findings include: On October 9, 2023, between 4:50 p.m. and 5:30 p.m., survey staff toured the facility with	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 8 unlicensed personnel (ULP)-B. During the facility tour, survey staff observed in resident bedroom 3 that the door knob had been replaced with a deadbolt lock that was operated using a thumb turn or keypad. Door hardware must be provided on bedroom doors that allow the occupant to open and close the door to ensure resident safety and privacy. This deficient condition was verified by ULP-B accompanying on the facility tour. 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, 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	{0 810}		

Minnesota Department of Health

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{0 810}	Continued From page 9 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 a fire safety and evacuation plans with the required elements; failed to provide the required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation; and failed to complete the required employee 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) 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 October 9, 2023, between 4:50 p.m. and 5:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that a room in the	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 10 basement was occupied and being used as a resident bedroom. The floor plans posted in the facility identified this room as a lounge. This deficient condition was verified by ULP-B accompanying on the facility tour. On October 9, 2023, at approximately 5:20 p.m., survey staff requested the fire safety and evacuation plans, employee and resident training records for fire safety and evacuation, and evacuation drill records. ULP-B explained that this documentation was not available. ULP-B further explained that the fire safety and evacuation plans were stored in a locked location, and they did not have a key. The fire safety and evacuation plans were not readily available. This deficient condition was verified by ULP-B accompanying on the facility tour. On October 9, 2023, at approximately 5:20 p.m., the ULP-B stated that all the requested documentation for fire safety and evacuation would be emailed to survey staff. As of October 19, 2023, survey staff had not received an email from the licensee with the requested documentation. 1. Documentation was not provided by the licensee to support that the fire safety and evacuation plans had been developed for the facility location. 2. Documentation was not provided by the licensee to support that the plans included employee actions on how to move or evacuate residents in the event of a fire or similar emergency. 3. Documentation was not provided by the licensee to support that the plans included fire protection procedures necessary for residents.	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 11 4. Documentation was not provided by the licensee to support that the plans included 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. 5. Documentation was not provided by the licensee to support that employee training had been completed. 6. Documentation was not provided by the licensee to support that residents capable of assisting in their own evacuation had been trained on the proper actions to take in the event of a fire. 7. Documentation was not provided by the licensee to support that evacuation drills had been completed. No further information was provided.	{0 810}			
{0 820} SS=D	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	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 12 by: Based on observation and interview, the licensee failed to provide an egress window that met the minimum width opening requirement. This had the potential to directly affect one resident and all staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). On October 9, 2023, between 4:50 p.m. and 5:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that the clear openable width of the egress window measured 19.25 inches in resident sleeping room 4 which was unoccupied at the time of survey. The egress windows did not meet the minimum width opening requirement for resident egress of 20 inches minimum. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet). This deficient condition was verified by ULP-B accompanying on the facility tour.	{0 820}			
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services	{01460}			

Minnesota Department of Health

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{01460}	Continued From page 13 must complete an orientation to assisted living facility licensing requirements and regulations 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: No further action needed.	{01460}			
{01610} SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: No further action needed.	{01610}			

Minnesota Department of Health

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{01620}	Continued From page 14	{01620}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of 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: No further action needed.	{01620}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 10, 2023

Licensee
Caring Angels
9130 Louisiana Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL38746015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on July 19, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; however, no immediate fines are assessed for this survey of your facility.

DOCUMENTATION OF ACTION TO COMPLY

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

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

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Rhylee Gilb". The signature is fluid and cursive, with a large, stylized initial "R" and a distinct "G" for the last name.

Rhylee Gilb, Supervisor
State Rapid Response Team
Email: rhylee.gilb@state.mn.us
Telephone: 218-232-8285 Fax: 651-215-6894

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2023
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #SL38746015 On July 17, 2023 through July 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two (2) residents receiving services under the provider's Assisted Living license.	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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
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 licensed assisted living director (LALD)-E listed himself as Director of Records with the Board of Executives for Long-Term Services and Supports (BELTSS). 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 the potential to affect a large portion or all the residents). The findings include: During an interview on July 19, 2023 at 10:55 a.m., unlicensed personnel (ULP)-B stated registered nurse (RN)-D had to remove himself as Director of Records with BELTSS so LALD-E could add himself. At the time of the survey, LALD-E held an active assisted living director license but failed to list himself as Director of Records with BELTSS. At the time of the survey, RN-D, who had previously been LALD for the licensee, held an active assisted living director license but listed himself as Director of Records with BELTSS for a different licensee.	0 110			

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NAME OF PROVIDER OR SUPPLIER CARING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445			
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0 110	Continued From page 2	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 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 a staffing plan which	0 470			

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0 470	Continued From page 3 included staffing levels. Additionally, the licensee lacked evidence the staffing plan was reviewed twice per year. This had the ability to affect all resident and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The Facility Staffing Plan, undated, failed to indicate the licensee's staffing schedule based on the metrics identified in the plan, an evaluation of the appropriateness of staffing levels, and documentation of review dates. During an interview on July 18, 2023 at 11:15 a.m., registered nurse (RN)-D stated the staffing plan had been reviewed in March. The licensee did not document the review. 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	0 480			

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0 480	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 17, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide	0 490			

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0 490	Continued From page 5 reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a daily program of social and recreational activities. This had the ability to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 19, 2023 at 9:45 a.m., the licensee-provided Survey Binder, undated, lacked a daily activity program of social and recreational activities. During an observation on July 19, 2023 at 9:50 a.m., the licensee lacked a daily activity program posted in the facility.	0 490			

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0 490	Continued From page 6 During an interview on July 19, 2023 at 10:00 a.m., unlicensed personnel (ULP)-A stated she had started creating an activity schedule. The licensee policy Activity Programming dated July 21, 2023, indicated a monthly activities calendar would be created and made available to all residents including social, religious, and cultural events, exercise and wellness, as well as volunteer, creative, and intellectual opportunities. This policy failed to address the requirement of a daily program of activities based upon individual and group interests and other topics in accordance with Minnesota Statutes 144G. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 490			
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff had access to a registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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	0 495			

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0 495	Continued From page 7 of the residents). The findings include: During an interview on July 17, 2023, at 9:48 a.m., unlicensed personnel (ULP)-A stated RN-C has been in Kenya, Africa. During the entrance conference on July 17, 2023, at 9:55 a.m., ULP-A attempted to call RN-C for the interview, but the call dropped. ULP-A called again, but RN-C did not answer. ULP-A called RN-C once more, but the call ended again due to poor service. ULP-A stated RN-B was busy and not doing anything as the backup RN since he worked elsewhere. ULP-A attempted to call RN-B. ULP-A stated RN-B could not answer her call due to his other job. She stated the RN needed to be available. On July 17, 2023 at 10:13 a.m., ULP-A stated RN-B called back but could not come to the licensee until the next day due to being onsite at another assisted living facility. The licensee policy Availability of an RN for Staff, undated, indicated the RN must be readily available either in person, by telephone, or by other means. TIME PERIOD FOR CORRECTION: Two (2) Days	0 495			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality	0 580			

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0 580	Continued From page 8 management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and document quality management activity. This had the ability to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 an interview on July 18, 2023, at 11:15 a.m., registered nurse (RN)-D stated he did not think the licensee documented meeting minutes and could not recall the last time they held a meeting. RN-D stated it had been a while. The licensee Quality Management Program, undated, referenced Minnesota Statutes 144A. The licensee policy Quality Management Project,	0 580			

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0 580	Continued From page 9 dated November 1, 2022, indicated the licensee would have at least one documented quality management project in place at all times and retain records of such projects for at least two years. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 580			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	0 650			

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0 650	Continued From page 10 Based on interview and record review, the licensee failed to ensure employee records contained all required content for two of two employees (unlicensed personnel (ULP)-B, registered nurse (RN)-C). 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: ULP-B started at the licensee November 10, 2022. ULP-B's record lacked documentation of a completed 30-day supervision. RN-C started at the licensee June 1, 2023. RN-C's record lacked her current professional nursing license, completed orientation records, infection control training, and a job description. During an interview on July 17, 2023 at 9:55 a.m., ULP-A stated she thought she was aware of the required contents of the employee records. During an interview on July 18, 2023 at 11:55 a.m., RN-D stated 30-day supervisions were completed and documented for ULPs. The licensee-provided policy Employee Records, dated November 1, 2022, indicated employee records for each person would include evident of current professional license, records of all training, current and signed job description, and verification of completed orientation.	0 650			

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0 650	Continued From page 11	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an emergency preparedness plan including all	0 680			

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0 680	Continued From page 12 required content. This had the ability to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an observation on July 17, 2023, at 11:10 a.m., the licensee did not have an emergency disaster plan posted prominently. During an observation on July 17, 2023, at 11:20 a.m., the licensee did not have an emergency exit diagram posted on the upper level of the building which included bedrooms one through three. During an observation on July 17, 2023, at 11:22 a.m., the licensee did not have an emergency exit diagram posted on the lower level which included a community room, bedroom four, and the door to bedroom five. During an observation on July 17, 2023, at 11:23 a.m., the licensee did not have an emergency exit diagram posted in the basement which included bedroom five. During an interview on July 17, 2023, at 10:10 a.m., unlicensed personnel (ULP)-A stated the licensee purchased the policies and procedures from Care Providers. During an interview on July 18, 2023, at 11:39	0 680			

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0 680	Continued From page 13 a.m., ULP-A stated licensed assisted living director (LALD)-E took the risk assessment somewhere. Registered nurse (RN)-D stated the plan is reviewed and updated annually and as needed. The Emergency Preparedness Program, undated, did not get completed by the licensee after receiving from Care Providers. This document did not include effective or review dates, the name of the licensee, or any other individualized information specific to the licensee. This document included blank communication, emergency, and evacuation plans, a section to document community-wide drills and tabletop exercises without documentation, a blank vendor list, and policies not updated to include to the licensee's name. This document lacked a documented risk assessment. The licensee policy Emergency Preparedness Plan - Appendix Z Compliance, dated November 1, 2022, indicated the licensee had in place an effective and compliant emergency preparedness plan. This policy indicated the emergency preparedness plan would include all required elements of Appendix Z. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 680			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780			

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0 780	Continued From page 14 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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 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).	0 780			

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0 780	Continued From page 15 Findings include: On July 17, 2023, between 10:30 a.m. and 11:30 a.m., survey staff toured the facility with unlicensed personnel (ULP)-A and unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that a smoke alarm was not installed outside sleeping rooms 4 and 5 in the immediate vicinity of bedrooms. This deficient condition was verified by ULP-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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.	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2023
NAME OF PROVIDER OR SUPPLIER CARING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 16 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 July 17, 2023, between 10:30 a.m. and 11:30 a.m., survey staff toured the facility with unlicensed personnel (ULP)-A and unlicensed personnel (ULP)-B. During the facility tour, survey staff observed the following: 1. The egress window in resident bedroom 5 was very difficult to open and required considerable force by ULP-B to open fully. Egress windows must be maintained in a state of good repair, to allow exiting the building in a safe and efficient manner in the event of an emergency. 2. A space heater in resident room 5 did not have a safety certification label. 3. The family room patio door was designated as an exit and not operating smoothly, making it difficult to open. A sliding bolt-style lock was installed near the top of the front door. Exit doors must be maintained in a state of good repair, to allow exiting the building in a safe and efficient manner in the event of an emergency. 4. An exit sign was posted directing occupants to exit the building through the garage. Exits are required to lead directly to the exterior of the building and not through a higher hazard room. 5. The smoke alarm installed in the hallway outside resident rooms 1, 2, and 3 did not sound an alarm when tested by ULP-B. 6. A knob was missing from one side of the bifold	0 800			

Minnesota Department of Health

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0 800	Continued From page 17 closet in resident room 3, which made it difficult to operate. 7. Screens were not installed on the windows for resident rooms 2 and 3. The window was open in resident room 2 during the facility tour. 8. Paper had been placed inside the ceiling light fixture in resident room 2, creating a potential fire hazard. 9. The light fixture was missing a cover near the front door on the exterior of the building. These deficient conditions were verified by ULP-A accompanying on the facility tour. 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, 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	0 810			

Minnesota Department of Health

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0 810	Continued From page 18 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 a fire safety and evacuation plans with required elements; failed to provide the required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation; and failed to complete the required employee 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) 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 July 17, 2023, between 10:30 a.m. and 11:30 a.m., survey staff toured the facility with	0 810			

Minnesota Department of Health

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0 810	Continued From page 19 unlicensed personnel (ULP)-A and unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that resident room 5 was not included on the evacuation maps posted in the facility. On July 17, 2023, at approximately 11:30 a.m., records were provided for review. Records were reviewed by survey staff on July 17, 2023, between 11:30 a.m. and 12:00 p.m. 1. Record review of the available documentation indicated that the fire safety and evacuation plans had not been developed and maintained for the facility location. a. The facility site map page was blank in the plans. b. The licensee had not developed plans with employee actions on how to move or evacuate residents in the event of a fire or similar emergency from this facility location. c. The licensee had not developed plans with fire protection procedures necessary for residents from this facility location. d. The licensee had not developed plans with 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 in the plans from this facility location. 2. Record review of the available documentation indicated that the facility had the correct employee training frequency in policy for the fire safety and evacuation plans but no training records to support that employee training had been completed were provided. The ULP-B explained during an interview that employees had completed fire safety training on EduCare. The employee training frequency requirement of upon	0 810			

Minnesota Department of Health

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0 810	Continued From page 20 hiring and at least twice per year thereafter was not met. 3. Record review of the available documentation indicated that the facility had the correct resident training frequency in policy but no training records were provided to support that annual resident training had been completed on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The ULP-B explained during an interview that residents had been trained but this had not been documented. 4. Record review of the available documentation indicated that the facility had the correct evacuation drill frequency in policy but the fire drill matrix and fire drill reports were blank. The ULP-B explained during an interview that evacuation drills had been completed but were not documented. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On July 17, 2023, at approximately 12:00 p.m., unlicensed personnel (ULP)-A verbally verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=E	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	0 820			

Minnesota Department of Health

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0 820	Continued From page 21 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 provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 July 17, 2023, between 10:30 a.m. and 11:30 a.m., survey staff toured the facility with unlicensed personnel (ULP)-A and unlicensed personnel (ULP)-B. During the facility tour, survey staff observed that the clear openable width of the egress windows measured less than 20 inches in resident sleeping rooms 1 and 4, which were unoccupied at the time of survey. These egress windows did not meet the minimum width opening requirement for resident egress of 20 inches minimum. One window in each resident	0 820			

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0 820	Continued From page 22 bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet). These deficient conditions were verified by ULP-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820			
01460 SS=D	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 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 interview and record review, the licensee failed to ensure one of two employees (registered nurse (RN)-C) completed orientation prior to providing services to 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 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).	01460			

Minnesota Department of Health

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01460	Continued From page 23 The findings include: RN-C started at the licensee June 1, 2023. RN-C's record included an unsigned, undated, orientation checklist. This checklist did not indicate whether RN-C completed the orientation topics. RN-C completed an assessment for one of the residents on June 9, 2023. During an interview on July 19, 2023 at 10:50 a.m., unlicensed personnel (ULP)-A stated there were still orientation topics RN-C needed to complete. The licensee policy Orientation of Staff and Supervisors & Content, dated November 1, 2022, indicated all staff providing and supervising direct services must have completed an orientation before providing assisted living services to residents. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	01460			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01610			

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01610	Continued From page 24 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a nursing assessment on or before move-in for one of one 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) 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 admitted to the licensee November 5, 2022. R1's diagnoses included diabetes mellitus, hypertension, and Alzheimer's disease. R1's service plan dated December 4, 2022, indicated R1 received assistance with bathing, escorts, behavior management, and medication administration. R1's record lacked documentation of a physical and cognitive assessment completed on or before her move-in on November 5, 2022.	01610			

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01610	Continued From page 25 R1's record included a nursing assessment dated November 25, 2022. During an interview July 18, 2023 at 11:15 a.m., registered nurse (RN)-D stated assessments were completed upon admission. During an interview July 18, 2023 at 1:45 p.m., unlicensed personnel (ULP)-A stated R1 lived at the licensee between November 5, 2022 and November 25, 2022. The licensee policy Assessments, Reviews, & Monitoring, dated "11/1/2", indicated a RN would conduct a nursing assessment of the physical and cognitive needs of the prospective resident prior to or on move-in. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	01610			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620			

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01620	Continued From page 26 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 complete 14 and 90-day assessments on one of one 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) 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 admitted to the licensee November 5, 2022. R1's diagnoses included diabetes mellitus, hypertension, and Alzheimer's disease. R1's service plan dated December 4, 2022, indicated R1 received assistance with bathing, escorts, behavior management, and medication administration. R1's record lacked a 14-day assessment due November 19, 2022. R1's record included a nursing assessment dated	01620			

Minnesota Department of Health

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01620	Continued From page 27 November 25, 2022. R1's record lacked a 90-day assessment due February 23, 2023. R1's record lacked a 90-day assessment due May 24, 2023. R1's record included a 90-day assessment dated June 9, 2023. During an interview on July 18, 2023, at 11:15 a.m., registered nurse (RN)-D stated assessments were completed upon admission, after 14 days, and at 90 days. During an interview on July 19, 2023, at 10:00 a.m., unlicensed personnel (ULP)-A stated she could not find the 14 and 90-day assessments. The licensee policy Assessments, Reviews, & Monitoring, dated "11/1/2", indicated resident reassessment and monitoring must have been conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must have been conducted no more than 90 calendar days from the date of the last assessment. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	01620			



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

Type: Full
Date: 07/17/23
Time: 14:10:47
Report: 8058231151

Food and Beverage Establishment Inspection Report

Page 1

Location:

Caring Angels
9130 Louisiana Avenue N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0041339
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2

**** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

ADJUSTED COOLER ON SITE

Comply By: 07/17/23

2-100 Supervision

2-102.12AMN

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

PERSON IN CHARGE IS IN THE PROGRESS OF OBTAINING CFPM

Comply By: 09/30/23

Food and Equipment Temperatures

Process/Item: DELI MEAT

Temperature: 43 Degrees Fahrenheit - Location: COOLER

Violation Issued: Yes

Process/Item: TOMATO

Temperature: 43 Degrees Fahrenheit - Location: COOLER

Violation Issued: Yes

Type: Full
Date: 07/17/23
Time: 14:10:47
Report: 8058231151
Caring Angels

Food and Beverage Establishment Inspection Report

Page 2

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

RESIDENTIAL HOME IN RESIDENTIAL NEIGHBORHOOD, WOOD CABINETS, STONE COUNTER, CERAMIC TILE AND PAINTED SHEETROCK

RESIDENTIAL EQUIPMENT

DISCUSSED ILLNESS POLICY WITH PERSON IN CHARGE

HRD INSPECTOR: Nicole Myslicki

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 8058231151 of 07/17/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

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