



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

August 2, 2022

Administrator  
Paradise Care Homes, LLC  
7709 Unity Avenue North  
Brooklyn Park, MN 55443

RE: Project Number(s) SL34668015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

#### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program \$500.00**

**The total amount you are assessed is \$500.00.** You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

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

Please address your cover letter for general reconsideration requests to:

Free from Maltreatment reconsideration requests should be addressed to:

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

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

**REQUESTING A HEARING**

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

**Health.HRD.Appeals@state.mn.us.**

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

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

Sincerely,



Casey DeVries, Supervisor  
State Evaluation Team  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 3879  
St. Paul, MN 55101-3879  
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                        |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X5)<br>COMPLETE<br>DATE                               |
| 0 000                                                              | <p>Initial Comments</p> <p>Initial comments<br/>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)<br/>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.<br/>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.<br/>INITIAL COMMENTS:<br/>SL34668015-0<br/>On July 11, 2022, through July 13, 2022, the<br/>Minnesota Department of Health conducted a<br/>survey at the above provider, and the following<br/>correction orders are issued. At the time of the<br/>survey, there were three residents, all of whom<br/>received services under the provider's Assisted<br/>Living license.</p> | 0 000                                                                                               | <p>Minnesota Department of Health is<br/>documenting the State Licensing<br/>Correction Orders using federal software.<br/>Tag numbers have been assigned to<br/>Minnesota State Statutes for Assisted<br/>Living License Providers. The assigned<br/>tag number appears in the far-left column<br/>entitled "ID Prefix Tag." The state Statute<br/>number and the corresponding text of the<br/>state Statute out of compliance is listed in<br/>the "Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the surveyors'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>The letter in the left column is used for<br/>tracking purposes and reflects the scope<br/>and level issued pursuant to 144G.31<br/>subd. 1, 2, and 3.</p> |                                                        |
| 0 110<br>SS=F                                                      | 144G.10 Subdivision 1a Assisted living director<br>license required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0 110                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                        |

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 110                                                              | <p>Continued From page 1</p> <p>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's three residents, staff and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>Licensed assisted living director (LALD)-C obtained an assisted living director license on June 22, 2021.<br/>On July 11, 2022, at approximately 8:57 a.m., during the entrance conference, registered nurse (RN)-A identified LALD-C as the LALD for the licensee.</p> <p>On July 11, 2022, at 9:55 a.m., the surveyor observed the Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-C held a current assisted living director license but was not listed as Director of Record for the licensee.</p> | 0 110                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 110                                                              | Continued From page 2<br><br>On June 11, 2022, at approximately 11:54 a.m., RN-A verified LALD-C were not listed as the Director of Record for the licensee. RN-A stated the licensee knew about the requirement however, when LALD-C attempted to register as Director of Record, the facility location was not available to choose.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0 110                                                                                               |                                                                                                                          |                                                        |
| 0 430<br>SS=C                                                      | 144G.40 Subd. 2 Uniform checklist disclosure of services<br><br>(a) All assisted living facilities must provide to prospective residents:<br>(1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility;<br>(2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and<br>(3) an oral explanation of the services offered under the contract.<br>(b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract.<br>(c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the | 0 430                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 430                                                              | <p>Continued From page 3</p> <p>licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to three of three residents (R1, R2, R3) with records reviewed.</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>R1<br/>R1 admitted for service on August 8, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.</p> <p>R1's Service Plan dated December 21, 2021, indicated R1 received assistance with daily supervision of dressing, verbal medication reminders, medication administration, meals, blood glucose checks, hands on assistance with mobility, laundry, housekeeping and daily safety checks.</p> <p>R2<br/>R2 admitted for service on September 12, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.</p> <p>R2's Service Plan dated December 20, 2021, indicated R2 received assistance with verbal medication reminders, medication administration, meals, personal laundry, housekeeping and daily</p> | 0 430                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 430                                                              | <p>Continued From page 4</p> <p>safety checks.</p> <p>R3<br/>R3 admitted for service on May 18, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.</p> <p>R3's Service Plan dated December 20, 2021, indicated R3 received assistance with verbal and visual medication reminders, medication administration, laundry, housekeeping, behavioral support and daily safety checks.</p> <p>R1, R2 and R3's record included Statement of Home Care Services: Comprehensive Home Care Provider dated August 8, 2019, September 12, 2019, and May 18, 2020, respectively. R1, R2, and R3's record lacked a UDALSA to include:</p> <ul style="list-style-type: none"> <li>- a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and</li> <li>- a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide.</li> </ul> <p>On July 11, 2022, at 1:38 p.m., registered nurse (RN)-A verified R1, R2, and R3's record lacked a UDALSA. RN-A stated the licensee had provided the UDALSA to residents when licensee renewed resident's contracts however, did not keep a record that it was provided.</p> <p>The licensee's Uniform Disclosure of Assisted Living Services &amp; Amenities (UDALSA) policy dated September 1, 2021, indicated the licensee would provide a UDALSA to residents prior to</p> | 0 430                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 430                                                              | Continued From page 5<br><br>signing an assisted living contract.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0 430                                                                                               |                                                                                                                          |                                                        |
| 0 460<br>SS=F                                                      | 144G.41 Subdivision 1 Minimum requirements<br><br>(5) provide a means for residents to request<br>assistance for health and safety needs 24 hours<br>per day, seven days per week;<br>(6) allow residents the ability to furnish and<br>decorate the resident's unit within the terms of the<br>assisted living contract;<br>(7) permit residents access to food at any time;<br>(8) allow residents to choose the resident's<br>visitors and times of visits;<br>(9) allow the resident the right to choose a<br>roommate if sharing a unit;<br>(10) notify the resident of the resident's right to<br>have and use a lockable door to the resident's<br>unit. The licensee shall provide the locks on the<br>unit. Only a staff member with a specific need to<br>enter the unit shall have keys, and advance<br>notice must be given to the resident before<br>entrance, when possible. An assisted living<br>facility must not lock a resident in the resident's<br>unit;<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation and interview, the licensee<br>failed to provide a means for residents to request<br>assistance for health and safety needs 24 hours a<br>day, seven days a week.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or | 0 460                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 460                                                              | <p>Continued From page 6</p> <p>safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>On July 11, 2022, at 9:02 a.m., registered nurse (RN)-A, verified the licensee lacked a system for residents to request staff assistance when needed 24 hours a day. RN-A stated residents would ambulate to the common area or yell to ask for assistance when needed.</p> <p>On July 11, 2022, at approximately 9:31 a.m., during the facility tour, the surveyor observed no system in place for residents to request staff assistance when needed 24 hours a day.</p> <p>On July 12, 2022, at 10:06 a.m., R2 stated they ambulated to the upstairs common area or would yell from the bottom of the steps to call for assistance.</p> <p>The licensee's 24-Hour Emergency Response policy dated September 1, 2021, indicated residents were given instruction on the use of emergency response system upon move in, ongoing, and as needed. In addition, residents would press a button or pull and emergency response cord that would activate the response system to notify a designated staff person.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 460                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470<br>SS=F                                                      | <p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(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</p> <p>(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;</p> <p>(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:</p> <p>(i) awake;</p> <p>(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;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure staff were capable of communicating with residents potentially affecting the licensee's three residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p> | 0 470                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                              | <p>Continued From page 8</p> <p>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).</p> <p>The findings include:</p> <p>On July 11, 2022, the surveyor observed another surveyor from the Minnesota Department of Health ask ULP-B questions regarding food code. ULP-B was unable to respond on topic of questions being asked. MDH surveyor asked ULP-B to contact their supervisor to assist with the survey process.</p> <p>On July 11, 2022, at approximately 2:02 p.m., R1 stated staff do not understand what residents ask for. In addition, R1 stated, "they keep saying yes but they don't understand me."</p> <p>On July 12, 2022, at approximately 8:04 a.m., ULP-E stated to surveyor, "Do you need anything else because the other guy does not speak English well, but he knows his job and has been trained."</p> <p>On July 12, 2022, at approximately 10:11 a.m., R2 stated staff occasionally do not understand residents.</p> <p>On July 12, 2022, at approximately 11:40 a.m., the surveyor observed R1 explain how to make a grill cheese sandwich to ULP-B.</p> <p>On July 12, 2022, at approximately 11:51 a.m., the surveyor observed ULP-B give R1 a plate that contained bread cooked on one side and cheese on the other side with a full stick of butter and a</p> | 0 470                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                              | Continued From page 9<br><br>spoon.<br><br>On July 12, 2022, at approximately 11:53 a.m.,<br>RN-A verified resident received a full stick of<br>butter with a spoon. RN-A stated ULP-B did not<br>understand R1's request. In addition, RN-A stated<br>competencies were used to ensure staff could<br>perform the job description.<br><br>On July 14, 2022, at approximately 10:50 a.m.,<br>RN-A stated staff contacted them if staff did not<br>understand what a resident asked for. In addition,<br>RN-A stated the resident's request would be<br>completed after they explained to staff the<br>resident's request in a way the staff would<br>understand.<br><br>No further information provided<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days | 0 470                                                                                               |                                                                                                                          |                                                        |
| 0 480<br>SS=F                                                      | 144G.41 Subd 1 (13) (i) (B) Minimum<br>requirements<br><br>(13) offer to provide or make available at least the<br>following services to residents:<br><br>(i) at least three nutritious meals daily with snacks<br>available seven days per week, according to the<br>recommended dietary allowances in the United<br>States Department of Agriculture (USDA)<br>guidelines, including seasonal fresh fruit and<br>fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according<br>to the Minnesota Food Code, Minnesota Rules,<br>chapter 4626; and                                                                                                                                                                        | 0 480                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 480                                                              | Continued From page 10<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review, the licensee failed to ensure food was<br>prepared according to the Minnesota Food Code.<br>This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety, but was not likely to<br>cause serious injury, impairment, or death), and<br>was issued at a widespread scope (when<br>problems are pervasive or represent a systemic<br>failure that has affected or has potential to affect<br>a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the additional documentation<br>included in the Food and Beverage Establishment<br>Inspection Reports, dated July 11, 2022.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days | 0 480                                                                                               |                                                                                                                          |                                                        |
| 0 485<br>SS=F                                                      | 144G.41 Subd 1. (13) (i) (A) and (C) Minimum<br>Requirements<br><br>(13) offer to provide or make available at least the<br>following services to residents:<br><br>(i) at least three nutritious meals daily with snacks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0 485                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 485                                                              | <p>Continued From page 11</p> <p>available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:</p> <p>(A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes;</p> <p>(C) the facility cannot require a resident to include and pay for meals in their contract;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure to offer at least three nutritious meals daily, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables, with records reviewed. The licensee also failed to post a menu a week in advance and inform residents in advance of menu changes. This had the potential to affect all three residents.</p> <p>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).</p> | 0 485                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 485                                                              | <p>Continued From page 12</p> <p>The findings include:</p> <p><b>NUTRITIOUS MEALS</b><br/>The licensee's undated menu titled Monthly Meal Planner lacked consistent meals including half plate fruits and vegetables, one quarter plate protein and one quarter plate grains.</p> <p>On July 11, 2022, at approximately 9 a.m., the surveyor observed ULP-B prepare oatmeal for the residents for breakfast. The surveyor observed no additional food from other food groups.</p> <p>On July 12, 2022, at 8:17 a.m., the surveyor observed ULP-B prepare pancakes for the residents for breakfast. The surveyor observed no additional food from other food groups.</p> <p>On July 12, 2022, at 11:35 a.m., the surveyor observed ULP-B prepare fettucine noodles mixed with frozen vegetables and a fresh onion for the residents for lunch. The surveyor observed no additional food from other food groups. The meal lacked protein and fruit.</p> <p>On July 12, 2022, at 10:55 a.m. the surveyor observed the licensee's refrigerator which contained onions, cucumber, carrots, lettuce and peppers. The surveyor observed the refrigerator and freezer which included proteins and vegetables however, lacked seasonal fresh fruit. In addition, the surveyor observed a lack of fresh fruit in the kitchen cabinets, tables and counters.</p> <p>The licensee's Food Service &amp; Menu Planning policy dated August 1, 2021, indicated the licensee would provide or make available at least three meals daily with snacks seven days per</p> | 0 485                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 485                                                              | <p>Continued From page 13</p> <p>week according to the recommended dietary allowances in the USDA guidelines, including seasonal fresh fruit and fresh vegetables.</p> <p><b>MENU POSTING</b><br/>On July 11, 2022, at approximately 9:31a.m., during the facility tour, the surveyor observed an undated menu titled Monthly Meal Planner. The observed menu was not prepared at least one week in advance.</p> <p>On July 11, 2022, at approximately 9:44 a.m., RN-A stated the licensee posts a meal menu weekly.</p> <p>The licensee's Food Service &amp; Menu Planning policy dated August 1, 2021, indicated the licensee would prepare menus one week in advance and it would be made available to all residents.</p> <p><b>MENU CHANGES</b><br/>On July 11, 2022, the surveyor observed ULP-B make oatmeal to serve for the residents for breakfast. The posted undated Monthly Meal Planner indicated on July 11, 2022, residents would receive cereal, milk, fruit and oatmeal for breakfast.</p> <p>On July 12, 2022, at 8:17 a.m., the surveyor observed ULP-B make pancakes for the residents for breakfast. The posted undated Monthly Meal Planner indicated on July 12, 2022, residents would receive scrambled eggs, juice, toast with jelly for breakfast.</p> <p>On July 12, 2022, at 11:35 a.m., the surveyor observed ULP-B prepare fettucine noodles mixed with frozen vegetables and a fresh onion. The posted undated Monthly Meal Planner indicated</p> | 0 485                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 485                                                              | <p>Continued From page 14</p> <p>on July 12, 2022, residents would receive grilled cheese, tomato soup and fruit for lunch. In addition, the surveyor observed R1 with a raised voice ask ULP-B why the food on the menu was not being prepared.</p> <p>On July 11, 2022, at approximately 2:02 p.m., R1 stated the licensee did not provide the food listed on the menu. In addition, R1 stated the staff members do not know how to properly make food listed on the menu.</p> <p>On July 12, 2022, at approximately 10:11 a.m., R2 stated the licensee did not follow the meal menu. In addition, R2 stated, "this morning it was supposed to be eggs and this morning we only got pancakes only. We should have some sausage or bacon."</p> <p>On July 12, 2022, at approximately 11:37 a.m., the surveyor asked ULP-B why they were not making what was posted on the menu. ULP-B stated R1 did not eat a majority of the time. The surveyor asked ULP-B if they had asked the other residents what they wanted to eat. ULP-B stated, "Sometimes I do, sometimes I do not. I make what I can."</p> <p>On July 12, 2022, at approximately 11:57 a.m., RN-A stated staff were to prepare and serve the food that was listed on the posted menu.</p> <p>The licensee's Food Service &amp; Menu Planning policy dated August 1, 2021, indicated the licensee would inform residents in advance of menu changes.</p> <p>No further information provided</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one</p> | 0 485                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 485                                                              | Continued From page 15<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0 485                                                                                               |                                                                                                                          |                                                        |
| 0 490<br>SS=F                                                      | 144G.41 Subd 1 (13) (ii)-(vii) Minimum<br>requirements<br><br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br>(iv) upon the request of the resident, provide<br>direct or reasonable assistance with arranging for<br>transportation to medical and social services<br>appointments, shopping, and other recreation,<br>and provide the name of or other identifying<br>information about the persons responsible for<br>providing this assistance;<br>(v) upon the request of the resident, provide<br>reasonable assistance with accessing community<br>resources and social services available in the<br>community, and provide the name of or other<br>identifying information about persons responsible<br>for providing this assistance;<br>(vi) provide culturally sensitive programs; and<br>(vii) have a daily program of social and<br>recreational activities that are based upon<br>individual and group interests, physical, mental,<br>and psychosocial needs, and that creates<br>opportunities for active participation in the<br>community at large; and<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review, the licensee failed to have a daily<br>program of social and recreational activities<br>based on individual and group interests, physical,<br>mental, and psychosocial needs, that create<br>opportunities for active participation in the<br>community at large. This had the potential to | 0 490                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b>                      |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 490                                                              | <p>Continued From page 16</p> <p>affect all three residents of the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On July 11, 2022, the surveyor did not observe any activities planned or offered to the residents. Residents remained in their rooms, outside or in the kitchen.</p> <p>On July 11, 2022, at approximately 2:02 p.m., R2 stated the licensee did not provide entertainment for residents.</p> <p>On July 12, 2022, at approximately 9:05 a.m., registered nurse (RN)-A stated the licensee previously provided daily recreational activities, however, no longer offered activities due to resident refusals. In addition, RN-A stated licensee bought R2 an XBOX to keep R2 entertained.</p> <p>On July 12, 2022, at approximately 10:11 a.m., R2 stated the licensee had provided limited activities since the pandemic.</p> <p>The licensee's Activity Programming policy dated September 1, 2022, indicated the licensee would provide activities and social recreation for residents. In addition, a monthly activity calendar would be created and made available to</p> | 0 490                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 490                                                              | Continued From page 17<br><br>residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 490                                                                                               |                                                                                                                          |                                                        |
| 0 510<br>SS=F                                                      | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and<br>maintain an infection control program that<br>complies with accepted health care, medical, and<br>nursing standards for infection control.<br>(b)The facility's infection control program must be<br>consistent with current guidelines from the<br>national Centers for Disease Control and<br>Prevention (CDC) for infection prevention and<br>control in long-term care facilities and, as<br>applicable, for infection prevention and control in<br>assisted living facilities.<br>(c) The facility must maintain written evidence of<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review the licensee failed to establish and<br>maintain an effective infection control program to<br>comply with accepted health care, medical, and<br>nursing standards for infection control and current<br>recommendations for Coronavirus (COVID-19).<br>This practice had the potential to affect the<br>licensee's three residents, staff and visitors.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety) and was issued at a<br>widespread scope (when problems are pervasive | 0 510                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                              | <p>Continued From page 18</p> <p>or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p><b>HAND HYGIENE</b><br/>On July 11, 2022, to July 12, 2022, the surveyor observed no paper towels in bathrooms. The surveyor asked ULP-B approximately five times for paper towels for hand hygiene.</p> <p>On July 12, 2022, at 8:17 a.m., the surveyor observed ULP-B prepare breakfast without completion of hand hygiene.</p> <p>On July 12, 2022, at approximately 11:11 a.m., the surveyor observed ULP-B prepare R1's medication without completion of hand hygiene.</p> <p>On July 12, 2022, at approximately 11:38, the surveyor observed ULP-B prepare R3's medication without completion of hand hygiene.</p> <p>On July 12, 2022, at 11:17 a.m., R1 asked RN-A for paper towel to place medication on. RN-A stated, "we do have paper towels just not enough for the bathroom." The surveyor observed R1 did not receive a paper towel from RN-A.</p> <p>On July 12, 2022, at 11:53 a.m., RN-A stated staff were trained to wash their hands prior to medication administration.</p> <p>On July 12, 2022, at 11:57 a.m., the surveyor observed ULP-B take a noodle out of a pot and lick hand to eat the noodle. ULP-B proceeded to cook food for resident's lunches without completion of hand hygiene. The surveyor asked ULP-B when they wash hands. ULP-B stated,</p> | 0 510                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                              | <p>Continued From page 19</p> <p>"yes, I wash hands."</p> <p>On July 14, 2022, at approximately 10:40 a.m., RN-A stated two supervisors were in charge of ordering supplies however, ULP's did not communicate the need for supplies which included paper towels. In addition, RN-A stated staff were trained to wash hands throughout the day, before meal preparation, before and after a medication administration, if a staff face was touched, and when staff had contact with a resident.</p> <p>The Centers for Disease Control and Prevention (CDC) Hand Hygiene in a Health Care Settings dated March 21, 2022, directed health care workers to wash their hands for at least 20 seconds with soap and water when hands are visibly dirty, before eating, after using restroom, and after caring for people.</p> <p>The CDC's When and How to Wash Your Hands dated March 14, 2022, indicated hand washing was needed before during and after preparing food. In addition, it directed people to dry hands using a clean towel.</p> <p>COVID-19<br/>On July 11, 2022, the surveyor observed RN-A, ULP-B and ULP-D throughout the facility without a mask. In addition, the surveyor observed no use of eye wear protection from RN-A, ULP-B and ULP-D. The surveyor observed residents ambulating throughout the facility in the common areas and within six feet of all the staff members listed.</p> <p>On July 11, 2022, at approximately 11:00 a.m., the surveyor observed another surveyor from Minnesota Department of Health (MDH) enter the</p> | 0 510                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                              | <p>Continued From page 20</p> <p>facility without staff screening for COVID-19.</p> <p>On July 12, 2022, the surveyor observed no use of eye wear protection from RN-A and ULP-B throughout the facility with residents ambulating in the common areas and were within six feet of all the staff members listed.</p> <p>On July 12, 2022, from approximately 7:55 a.m. to 8:30 a.m., the surveyor observed RN-A, ULP-B, and ULP-E throughout the facility without a mask. The surveyor observed residents ambulating throughout the facility in the common areas and within six feet of all the staff members listed.</p> <p>On July 12, 2022, at 8:04 a.m., ULP-E stated staff never wore eye wear in the facility. In addition, ULP-E stated masks were worn occasionally in the facility and they forgot to put one on last night.</p> <p>On July 12, 2022, at 8:05 a.m., ULP-B stated masks were worn only when residents or staff were ill because the licensee had a low supply of masks in the medication closet.</p> <p>On July 12, 2022, at approximately 8:15 a.m., the surveyor observed the medication closet which contained less than 40 masks.</p> <p>On July 12, 2022, at approximately 8:33 a.m., RN-A stated if staff or visitors were sick, staff would wear personal protective equipment (PPE). In addition, RN-A stated, "not going to lie, we really don't follow the CDC." The surveyor then observed RN-A place a mask on face and then direct ULP-B to place a mask on face. RN-A stated licensee did not have eyewear however, they would obtain eyewear later in the day.</p> | 0 510                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                              | <p>Continued From page 21</p> <p>On July 13, 2022, at approximately 11:30 a.m., environmental engineer surveyor from MDH entered the facility without staff screening for COVID-19.</p> <p>On July 13, 2022, at approximately 11:50 a.m., environmental engineer surveyor observed RN-A and ULP-B without a mask or eyewear.</p> <p>On July 14, 2022, at approximately 10:40 a.m., RN-A stated they did not wear a mask on July 13, 2022, because they were "rushing." In addition, RN-A stated on July 13, 2022, ULP-B should have worn a mask while in the facility and they were unaware of a reason why a mask was not worn.</p> <p>The licensee's Infection Control policy dated August 1, 2021, indicated the licensee's infection control program would be consistent with the current guidelines from the CDC.</p> <p>The CDC COVID Data Tracker indicated Hennepin County community transmission level were high on July 12, 2022.</p> <p>The CDC COVID-19 PPE and Source Control Grids dated April 7, 2022, indicated when a community transmission level was high, staff working with residents without COVID-19 should wear a face mask and eye protection.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p> | 0 510                                                                                               |                                                                                                                          |                                                        |
| 0 550<br>SS=F                                                      | 144G.41 Subd. 7 Resident grievances; reporting maltreatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0 550                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 550                                                              | <p>Continued From page 22</p> <p>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all three residents, staff and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On July 11, 2022, at approximately 9:31 a.m., during the facility tour, the surveyor observed the common areas shared by residents, staff and visitors lacked the required posting of the grievance procedure. The surveyor observed the grievance policy posted on a bulletin board in the common area which lacked the name, telephone</p> | 0 550                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b>                      |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 550                                                              | Continued From page 23<br><br>number and e-mail contact information for the individuals who were responsible for handling resident grievances.<br><br>On July 11, 2022, at approximately 9:45 a.m., registered nurse (RN)-A verified the posting lacked the above content. RN-A stated the licensee was not aware of requirement and the licensee had not received any complaints.<br><br>The licensee's Complaint/Grievance Posting policy dated September 1, 2021, indicated the licensee would post in a conspicuous place information for grievances with the contents listed above.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550                                                                     |                                                                                                                          |  |                                                        |
| 0 630<br>SS=F                                                      | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:                     | 0 630                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                              | <p>Continued From page 24</p> <p>Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for three of three residents (R1, R2, R3) with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R1<br/>R1 admitted for service on August 8, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.</p> <p>R1's diagnoses included traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), anxiety, congestive heart failure (CHF), and diabetes mellitus type 2 (DM2).</p> <p>R1's Vulnerability Assessment / Abuse Prevention Plan dated April 1, 2021, indicated R1 was at risk of abusing others, susceptible to abuse from others, and at risk for self-abuse. R1's abuse prevention plan failed to include statements of the specific measures to be taken to minimize the risk of abuse.</p> <p>R2<br/>R2 admitted for service on September 12, 2019, under the comprehensive home care license and</p> | 0 630                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                              | <p>Continued From page 25</p> <p>began receiving assisted living services on August 1, 2021.</p> <p>R2's diagnoses included paranoid schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), and tobacco abuse.</p> <p>R2's Vulnerability Assessment / Abuse Prevention Plan dated April 1, 2021, indicated R2 was at risk of abusing others, susceptible to abuse from others, and at risk for self-abuse. R2's abuse prevention plan failed to include statements of the specific measures to be taken to minimize the risk of abuse.</p> <p>R3<br/>R3 admitted for service on May 18, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.</p> <p>R3's diagnoses included coronary artery disease (CAD), and hypertension (HTN).</p> <p>R3's Vulnerability Assessment / Abuse Prevention Plan dated May 31, 2022, indicated R3 was susceptible to abuse from others, and at risk for self-abuse. R3's abuse prevention plan failed to include statements of the specific measures to be taken to minimize the risk of abuse.</p> <p>On July 11, 2022, at approximately 8:28 a.m., registered nurse (RN)-A verified R1, R2, R3's abuse prevention plans lacked statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. RN-A stated all resident's abuse plans would only include monitoring and reporting of abuse.</p> | 0 630                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                              | Continued From page 26<br><br>The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, indicated the licensee would include statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0 630                                                                                               |                                                                                                                          |                                                        |
| 0 680<br>SS=F                                                      | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(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. | 0 680                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                              | <p>Continued From page 27</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all three residents receiving services under the assisted living license.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On July 11, 2022, at approximately 11:15 a.m., the surveyor observed the licensee's EPP. The EPP had multiple areas of fill in the blanks that lacked licensee's information.</p> <p>The licensee's emergency disaster preparedness plan lacked evidence of the following required content:</p> <ul style="list-style-type: none"> <li>- a description of the population served by the licensee;</li> <li>- process for emergency plan (EP) collaboration;</li> <li>- subsistence needs for staff and residents;</li> <li>- procedures for tracking of staff and patients;</li> <li>- policies and procedure for medical documents;</li> <li>- policies and procedure for volunteers;</li> <li>- names and contact information; and</li> </ul> | 0 680                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                     |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                              | Continued From page 28<br><br>- emergency prep testing requirements.<br><br>On July 11, 2022, at 12:05 p.m., registered nurse (RN)-A verified the licensee's EPP lacked required content listed above. RN-A stated the licensee had record of emergency and fire drills at the office. Although requested, the surveyor did not receive drill records from RN-A during survey.<br><br>The licensee's Disaster Planning and Emergency policy dated August 1, 2021, indicated the licensee's EPP would comply with Centers for Medicare & Medicaid Services (CMS) Appendix Z.<br><br>The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would conduct two EP drills every twelve months.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680                                                                                               |                                                                                                                          |  |                                                        |
| 0 780<br>SS=F                                                      | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;                                                                                                                                                                                                                                                                                                                                                                                                            | 0 780                                                                                               |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 780                                                              | <p>Continued From page 29</p> <p>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>(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</p> <p>(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;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff.</p> <p>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:</p> <p>On July 13, 2022, between 11:30 a.m. and 12:00 p.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed that when smoke alarms in resident sleeping rooms and hallways were tested, none of the other alarms within the dwelling unit were activated. During the tour interview, the RN-A confirmed that smoke alarms were not interconnected so that actuation of one alarm caused all alarms in the dwelling unit to</p> | 0 780                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 780                                                              | Continued From page 30<br><br>operate.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 780                                                                                               |                                                                                                                          |                                                        |
| 0 800<br>SS=F                                                      | 144G.45 Subd. 2 (a) (4) Fire protection and<br>physical environment<br><br>(4) keep the physical environment, including<br>walls, floors, ceiling, all furnishings, grounds,<br>systems, and equipment in a continuous state of<br>good repair and operation with regard to the<br>health, safety, comfort, and well-being of the<br>residents in accordance with a maintenance and<br>repair program.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation and interview, the licensee<br>failed to provide the physical environment in a<br>continuous state of good repair and operation<br>with regard to the health, safety, and well-being of<br>the residents. This had the potential to directly<br>affect all residents and staff.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety) and was issued at a<br>widespread scope (when problems are pervasive<br>or represent a systemic failure that has affected<br>or has the potential to affect a large portion or all<br>of the residents). The findings include:<br><br>On July 13, 2022, between 11:30 a.m. and 12:00<br>p.m., survey staff toured the facility with the<br>registered nurse (RN)-A. During the facility tour, | 0 800                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                              | <p>Continued From page 31</p> <p>survey staff observed the following:</p> <p>1. The egress window in room 3 could not be opened to provide a clear openable area of at least 648 square inches. The LALD-A explained that they thought there was a problem with the window crank mechanism and that it required repair. The other window in this room was missing a handle and could not be opened to verify the size of the clear openable area. The LALD-A explained during the tour interview that this sleeping room was currently vacant and not being used. The LALD-A confirmed that the egress window in room 3 was required to open and function properly.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> <p>2. There was an in-ground drained outdoor pool in the backyard in disrepair. Survey staff entered the pool area through an unlocked gate. This pool area and unlocked gate pose a safety risk to residents and unauthorized access from the public. The unlocked gate also needs to be reviewed for compliance with city requirements.</p> <p>3. In resident room 4, items were stored and stacked in front of the egress window, restricting access to this area of the room.</p> <p>4. The carpet was soiled and stained on the stairs connecting the main floor with the basement.</p> <p>5. The bathroom exhaust vent covers were dusty.</p> <p>6. The floor in the laundry room was soiled.</p> <p>On July 13, 2022, during an interview with the RN-A, at approximately 12:30 p.m., they confirmed that these items required maintenance.</p> <p>No further information was provided.</p> | 0 800                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                           |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b>                      |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                              | Continued From page 32                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 800                                                                     |                                                                                                                          |  |                                                        |
|                                                                    | TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                           |                                                                                                                          |  |                                                        |
| 0 810<br>SS=F                                                      | 144G.45 Subd. 2 (b)-(f) Fire protection and<br>physical environment<br><br>(b) Each assisted living facility shall develop and<br>maintain fire safety and evacuation plans. The<br>plans shall include but are not limited to:<br>(1) location and number of resident sleeping<br>rooms;<br>(2) employee actions to be taken in the event of<br>a fire or similar emergency;<br>(3) fire protection procedures necessary for<br>residents; and<br>(4) procedures for resident movement,<br>evacuation, or relocation during a fire or similar<br>emergency including the identification of unique<br>or unusual resident needs for movement or<br>evacuation.<br>(c) Employees of assisted living facilities shall<br>receive training on the fire safety and evacuation<br>plans upon hiring and at least twice per year<br>thereafter.<br>(d) Fire safety and evacuation plans shall be<br>readily available at all times within the facility.<br>(e) Residents who are capable of assisting in<br>their own evacuation shall be trained on the<br>proper actions to take in the event of a fire to<br>include movement, evacuation, or relocation. The<br>training shall be made available to residents at<br>least once per year.<br>(f) Evacuation drills are required for employees<br>twice per year per shift with at least one<br>evacuation drill every other month. Evacuation of<br>the residents is not required. Fire alarm system<br>activation is not required to initiate the evacuation<br>drill. | 0 810                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                              | <p>Continued From page 33</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on document review and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff.</p> <p>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:</p> <p>On July 13, 2022, at approximately 12:00 p.m., the registered nurse (RN)-A provided documents for review. Documents were reviewed by survey staff on July 13, 2022, between 12:00 p.m. and 12:30 p.m.</p> <p>1. The plans for fire safety and evacuation were not developed and maintained for the facility location. The 9.06 Fire Policy dated 8-1-21 referenced smoke compartment doors and magnetic door holders, which were not identified in the plans. This policy references sprinklers and an alarm system wired directly to the fire department which the facility did not have.</p> <p>2. The licensee failed to provide employee training on the facility fire safety and evacuation plans. On July 13, 2022, at approximately 12:15 p.m., the RN-A explained that employees completed training using an online educational program but this training did not include the facility fire safety and evacuation plans.</p> <p>3. The fire safety and evacuation plans were not readily available within the facility. When survey</p> | 0 810                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b>                      |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                              | Continued From page 34<br><br>staff requested documentation for review on July 13, 2022, at approximately 12:00 p.m., the RN-A stated that they would bring these plans and policies in from the car.<br>4. The licensee failed to provide annual fire safety and evacuation training for residents. Documentation was requested by survey staff but not provided. On July 13, 2022, at approximately 12:15 p.m., the RN-A explained that residents were trained on how to use fire extinguishers but were not trained on the fire safety and evacuation plans.<br>5. The licensee failed to provide the required frequency for evacuation drills. Fire drill records were provided dated 8-6-21, 12-20-21, 3-7-22, 5-13-22, 5-30-22, and 6-13-22. On July 13, 2022, at approximately 12:30 p.m., the RN-A stated that none of these drills were completed during the second shift. The licensee did not meet the twice per year per shift with at least one evacuation drill every other month frequency requirement.<br><br>On July 13, 2022, at approximately 12:30 p.m., the RN-A confirmed during an interview that the licensee failed to develop and maintain the fire safety and evacuation plans. They also confirmed that the training and drill frequency requirements were not met.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810                                                                     |                                                                                                                          |  |                                                        |
| 01620<br>SS=F                                                      | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 01620                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01620                                                              | <p>Continued From page 35</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments to include all areas required on the uniform assessment tool for three of three residents (R1, R2, R3) with records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect</p> | 01620                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01620                                                              | <p>Continued From page 36</p> <p>a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1<br/>R1's Service Plan dated December 21, 2021, indicated R1 received assistance with daily supervision of dressing, verbal medication reminders, medication administration, meals, blood glucose checks, hands on assistance with mobility, laundry, housekeeping and daily safety checks.</p> <p>R2<br/>R2's Service Plan dated December 20, 2021, indicated R2 received assistance with verbal medication reminders, medication administration, meals, personal laundry, housekeeping and daily safety checks.</p> <p>R3<br/>R3's Service Plan dated December 20, 2021, indicated R3 received assistance with verbal and visual medication reminders, medication administration, laundry, housekeeping, behavioral support and daily safety checks.</p> <p>R1, R2 and R3's 90-day reassessments titled Skilled Services Reassessment/Supervisory Visit Record dated December 27, 2021, March 14, 2022, and May 31, 2022, respectively, lacked the following areas required on the uniform assessment tool:</p> <ul style="list-style-type: none"> <li>- the resident's personal lifestyle preferences;</li> <li>- activities of daily living;</li> <li>- instrumental activities of daily living;</li> <li>- physical health status;</li> <li>- emotional and mental health conditions;</li> <li>- cognition;</li> <li>- communication and sensory capabilities;</li> </ul> | 01620                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01620                                                              | Continued From page 37<br><br>- pain;<br>- skin conditions;<br>- nutritional and hydration status preferences; and<br>- risk indicators.<br><br>On July 11, 2022, at approximately 2:15 p.m.,<br>RN-A stated the licensee previously used a longer<br>assessment form which covered the required<br>content however, the licensee recently moved to<br>a short one-page assessment. In addition, RN-A<br>stated they were unaware of the requirement.<br><br>The licensee's Uniform Assessment Tool policy<br>dated August 1, 2021, indicated the licensee<br>would use the uniform assessment tool that<br>would address all of the required content listed<br>above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days | 01620                                                                                               |                                                                                                                          |                                                        |
| 01650<br>SS=F                                                      | 144G.70 Subd. 4 (f) Service plan, implementation<br>and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided,<br>the fees for services, and the frequency of each<br>service, according to the resident's current<br>assessment and resident preferences;<br>(2) the identification of staff or categories of staff<br>who will provide the services;<br>(3) the schedule and methods of monitoring<br>assessments of the resident;<br>(4) the schedule and methods of monitoring staff<br>providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service                                                                                                      | 01650                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01650                                                              | <p>Continued From page 38</p> <p>cannot be provided;<br/>(ii) information and a method to contact the facility;<br/>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and<br/>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R1, R2, R3) with records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1<br/>R1's diagnoses included traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), anxiety, congestive heart failure (CHF) and diabetes mellitus type 2 (DM2).</p> | 01650                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01650                                                              | <p>Continued From page 39</p> <p>R1's Service Plan dated December 21, 2021, indicated R1 received assistance with daily supervision of dressing, verbal medication reminders, medication administration, meals, blood glucose checks, hands on assistance with mobility, laundry, housekeeping, and daily safety checks. R1's service plan lacked the following required content:</p> <ul style="list-style-type: none"> <li>- a contingency plan that included the action to be taken if the scheduled service cannot be provided; and</li> <li>- the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</li> </ul> <p>R2</p> <p>R2's diagnoses included paranoid schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior) and tobacco abuse.</p> <p>R2's Service Plan dated December 20, 2021, indicated R2 received assistance with verbal medication reminders, medication administration, meals, personal laundry, housekeeping and daily safety checks. R2's service plan lacked the following required content:</p> <ul style="list-style-type: none"> <li>- a contingency plan that included the action to be taken if the scheduled service cannot be provided; and</li> <li>- the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</li> </ul> <p>R3</p> <p>R3's diagnoses included coronary artery disease (CAD) and hypertension (HTN).</p> | 01650                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01650                                                              | Continued From page 40<br><br>R3's Service Plan dated December 20, 2021, indicated R3 received assistance with verbal and visual medication reminders, medication administration, laundry, housekeeping, behavioral and safety checks. R3's service plan lacked the following required content:<br>- fees for service; and<br>- a contingency plan that included the action to be taken if the scheduled service cannot be provided.<br><br>On June 22, 2022, at 1:47 p.m., registered nurse (RN)-A verified R1, R2 and R3's service plans lacked the above content. RN-A stated the licensee did not understand the requirement of the contingency plan because they were a 24/7 facility. In addition, RN-A was unaware of why the circumstances in which emergency medical services are not to be summoned where not filled in on the service plans.<br><br>The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include the content listed above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01650                                                                                               |                                                                                                                          |                                                        |
| 01760<br>SS=F                                                      | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 01760                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01760                                                              | <p>Continued From page 41</p> <p>must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure medications were administered per providers orders and failed to ensure medication administration was documented accurately in the medication administration record (MAR) for two of two residents (R1, R3) with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p><b>MEDICATION DOCUMENTATION</b><br/>R1<br/>On July 12, 2022, at approximately 10:51 a.m., the surveyor observed ULP-B administer lisinopril 10 milligrams (mg), aspirin 81 mg chewable, metformin 2000 mg, gabapentin 2400 mg, furosemide 60 mg, metoprolol extended release (ER) 50 mg, glipizide ER 10 mg, and duloxetine delayed release (DR) 90 mg to R1. The surveyor</p> | 01760                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01760                                                              | <p>Continued From page 42</p> <p>observed ULP-B take the medication from the medication closet, open the pharmacy prefilled bubble pack that was labeled with the correct date and time and administer the medication to R1. The surveyor observed ULP-B walk away from R1 prior to R1's consumption of the medication. ULP-B did not utilize the MAR during the medication administration process which included documentation of the medication administration.</p> <p>On July 12, 2022, at approximately 11:40 a.m., the surveyor observed R1's medication, which ULP-B had delivered to R1 at 10:51 a.m., on the table in the common area.</p> <p>On July 12, 2022, at approximately 11:53 a.m., the surveyor observed R1 finish remaining medications.</p> <p>R3<br/>On July 12, 2022, at 11:38 a.m., the surveyor observed ULP-B take medication from the medication closet, tear off a prefilled bubble back and the hand bubble pack to R3. The surveyor observed R3 take medication bubble pack and place it in their shirt. The surveyor observed ULP-B walk away from R3 and attend to another task. The surveyor observed no use of MAR during the medication administration process which included documentation of the medication administration.</p> <p>On July 12, 2022, at approximately 11:57 a.m., ULP-B stated they signed the MAR at the end of the shift. The surveyor asked ULP-B how they were trained on medication administration. ULP-B stated, "we wrote on paper."</p> <p><b>MEDICATION ERROR</b></p> | 01760                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01760                                                              | <p>Continued From page 43</p> <p>R1's Service Plan dated December 21, 2021, indicated R1 received assistance with daily supervision of dressing, verbal medication reminders, medication administration, meals, blood glucose checks, hands on assistance with mobility, laundry, housekeeping, and daily safety checks.</p> <p>R1's MAR dated July 1, 2022, included a medication order for gabapentin 1200 mg three times per day at 8:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>On July 12, 2022, at approximately 10:51 a.m., the surveyor observed ULP-B administer gabapentin 2400 mg to R1.</p> <p>On July 12, 2022, at approximately 11:53 a.m., RN-A stated staff were to get the medication box, compare medications listed to the MAR, then document on what was administered. In addition, RN-A stated staff took a EduCare class on medication administration and received a competency evaluation prior to passing medication.</p> <p>On July 12, 2022, at approximately 11:57 a.m., the surveyor asked ULP-B if he gives the 8:00 a.m., and 12:00 p.m. medications together. ULP-B stated, "I will do everything from eight to four that is me. I will give whatever is needed."</p> <p>The licensee's Medication Management-Administration &amp; Set Up policy dated August 1, 2021, indicated the ULP would use the MAR for documenting medications would refer to the medication profile listing the medication name, dosage, date and time administered.</p> | 01760                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01760                                                              | Continued From page 44<br><br>The licensee's Medication and Treatment<br>Record- Documentation & Refusal dated August<br>1, 2021, indicated documentation would occur in<br>the MAR following medication assistance or<br>medication administration.<br>No further information provided<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 01760                                                                                               |                                                                                                                          |                                                        |
| 01890<br>SS=F                                                      | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for<br>immediate or later administration, must be kept in<br>the original container in which it was dispensed<br>by the pharmacy bearing the original prescription<br>label with legible information including the<br>expiration or beyond-use date of a time-dated<br>drug.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review the licensee failed to ensure time sensitive<br>medications were labeled with the date opened<br>and discarded when expired for three of three<br>residents (R1, R2, R3) with medication storage<br>reviewed.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety) and was issued at a<br>widespread scope (when problems are pervasive<br>or represent a systemic failure that has affected<br>or has the potential to affect a large portion or all<br>of the residents).<br><br>The findings include: | 01890                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                           |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b>                      |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01890                                                              | <p>Continued From page 45</p> <p><b>TIME SENSITIVE MEDICATION</b><br/>On July 12, 2022, at approximately 8:06 a.m., the surveyor observed R2's medication box which contained a used Lantus Solostar pen that lacked a label of date first used.</p> <p>FDA storage requirements for Lantus Solostar dated May 2019, indicated medication should be discarded after 28 days from date opened.</p> <p>The licensee's Medication-Prescription Drugs &amp; Prohibition policy dated August 1, 2021, indicated prescription drugs would be kept in the original container bearing the original prescription label with legible information that included the expiration or beyond use date of a time dated drug.</p> <p><b>EXPIRED MEDICATION</b><br/>On July 12, 2022, at approximately 8:06 a.m., the surveyor observed the locked medication closet which contained over the counter (OTC) medications, R1's medications, R2's medications and R3's medications. The OTC medication box contained ibuprofen 200 milligram (mg) tablets with expiration date of January 2022. R2's medication box contained loratadine 10mg tablets with expiration date of November 20, 2020, and polyethylene glycol 3350 with expiration date of April 1, 2021. R3's medication box contained naproxen 500 mg tablets with expiration date of June 3, 2020.</p> <p>On July 12, 2022, at 8:21 a.m., registered nurse (RN)-A verified the medications listed above were expired or did not contain a date open label. RN-A stated the licensee reviewed medications monthly and disposed any expired medication found. In addition, RN-A stated the licensee kept R3's</p> | 01890                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01890                                                              | Continued From page 46<br><br>medications because they were "afraid"<br>pharmacy would be unable to complete a refill,<br>and the Ibuprofen 200 mg tablets were only being<br>used by staff not residents.<br><br>The licensee's Medication Disposal policy dated<br>August 1, 2021, indicated the licensee would<br>dispose expired and discontinued medications in<br>accordance with accepted practices of the<br>Minnesota Board of Pharmacy.<br><br>No further information provided<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 01890                                                                                               |                                                                                                                          |                                                        |
| 01940<br>SS=D                                                      | 144G.72 Subd. 3 Individualized treatment or<br>therapy managemen<br><br>For each resident receiving management of<br>ordered or prescribed treatments or therapy<br>services, the assisted living facility must prepare<br>and include in the service plan a written<br>statement of the treatment or therapy services<br>that will be provided to the resident. The facility<br>must also develop and maintain a current<br>individualized treatment and therapy<br>management record for each resident which must<br>contain at least the following:<br>(1) a statement of the type of services that will be<br>provided;<br>(2) documentation of specific resident instructions<br>relating to the treatments or therapy<br>administration;<br>(3) identification of treatment or therapy tasks that<br>will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or<br>appropriate licensed health professional when a<br>problem arises with treatments or therapy | 01940                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                     |                                                                                                                          |                                                        |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01940                                                              | <p>Continued From page 47</p> <p>services; and<br/>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R1) who received treatments with record reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1<br/>R1's diagnoses included traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), anxiety, congestive heart failure (CHF) and diabetes mellitus type 2 (DM2).</p> <p>R1's Service Plan dated December 21, 2021, indicated R1 received assistance with daily supervision of dressing, verbal medication</p> | 01940                                                                                               |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b>                      |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01940                                                              | <p>Continued From page 48</p> <p>reminders, medication administration, meals, blood glucose checks, hands on assistance with mobility, laundry, housekeeping and daily safety checks.</p> <p>R1's provider orders signed December 9, 2021, included Libre 14-day reader for blood glucose monitoring.</p> <p>R1's record lacked a treatment management plan to include:</p> <ul style="list-style-type: none"> <li>-- documentation of specific resident instructions relating to the treatments or therapy administration;</li> <li>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</li> <li>- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions.</li> </ul> <p>On July 11, 2022, at approximately 9:55 a.m., RN-A stated the resident record was located at the office offsite. In addition, RN-A stated ULP's had access only to the medication administration record (MAR), task check off list, and care plan.</p> <p>On July 12, 2022, at approximately 8:58 a.m., RN-A verified the record at the home lacked the above content. In addition, RN-A stated the licensee had never thought about the content not being available to ULP.</p> <p>The licensee's Treatment &amp; Therapy Management Plan dated August 1, 2021, indicated the individualized treatment and therapy</p> | 01940                                                                     |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                    |                                                                                                                                                                                        |                                                                           |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34668</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARADISE CARE HOMES LLC</b> |                                                                                                                                                                                        |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7709 UNITY AVENUE NORTH<br/>BROOKLYN PARK, MN 55443</b>                      |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                           | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01940                                                              | Continued From page 49<br><br>management record would include the content<br>listed above.<br><br>No further information provided<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days | 01940                                                                     |                                                                                                                          |  |                                                        |

Type: Full  
Date: 07/11/22  
Time: 11:00:50  
Report: 1029221210

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Paradise Care Homes Llc  
7709 Unity Avenue North  
Brooklyn Park, MN55443  
Hennepin County, 27

**Establishment Info:**

ID #: 0037450  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6128596065  
ID #:

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

The following orders were issued during this inspection.

### 2-200 Employee Health

#### 2-201.11C

**\*\* Priority 1 \*\***

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG.

Comply By: 07/13/22

### 3-500B Microbial Control: hot and cold holding

#### 3-501.16A1

**\*\* Priority 1 \*\***

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

QUICK OATS COOKED AND LEFT ON STOVE TOP MEASURED 98°F. DISCARDED.

Comply By: 07/11/22

### 4-600 Cleaning Equipment and Utensils

#### 4-602.11A

**\*\* Priority 1 \*\***

MN Rule 4626.0845A Clean and sanitize food-contact surfaces of equipment and utensils: 1. before each use with a different type of raw animal food; 2. each time there is a change from working with raw foods to working with ready-to-eat foods; 3. between uses with raw fruits and vegetables and TCS foods; 4. before using or storing a food temperature measuring device; 5. at any time during the operation when contamination may have occurred.

ESTABLISHMENT NOT SANITIZING BEFORE DRYING UTENSILS AND DISHES. DISHWASHER NOT FUNCTIONAL. INSTRUCTED TO USE SINK OR LARGE CONTAINER TO SANITIZE ALL

Type: Full  
Date: 07/11/22  
Time: 11:00:50  
Report: 1029221210  
Paradise Care Homes Llc

# Food and Beverage Establishment Inspection Report

Page 2

FOOD-CONTACT SURFACES OF DISHES AND UTENSILS.

*Comply By: 07/11/22*

## **5-200C Plumbing: Maintenance, fixture location**

### **5-205.11AB \*\* Priority 2 \*\***

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

NO DEDICATED HANDWASHING SINK IN KITCHEN AREA.

*Comply By: 07/11/22*

## **2-300 Personal Cleanliness**

### **2-301.12C**

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.

NO PAPER TOWELS AT BATHROOM HANDWASHING SINK.

*Comply By: 07/11/22*

## **3-300C Protection from Contamination: equipment/utensils, consumers**

### **3-304.14B**

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET CLOTH NOT IN USE AND NOT IN SANITIZER SOLUTION.

*Comply By: 07/11/22*

## **3-500A Microbial Control: cooling**

### **3-501.13ABC**

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

TCS FOODS LEFT ON COUNTER TO THAW.

*Comply By: 07/11/22*

## **4-500 Equipment Maintenance and Operation**

### **4-501.11AB**

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

FIRE EXTINGUISHER WITHOUT ANY DATE OF SERVICE TAGS.

*Comply By: 07/15/22*

Type: Full  
Date: 07/11/22  
Time: 11:00:50  
Report: 1029221210  
Paradise Care Homes Llc

# Food and Beverage Establishment Inspection Report

Page 3

## 4-600 Cleaning Equipment and Utensils

### 4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

INTERIOR OF OVEN NOT CLEAN.

*Comply By: 07/11/22*

## 6-100 Physical Facility Construction Materials

### 6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

CEILING IS TEXTURED.

*Comply By: 07/31/23*

## 6-500 Physical Facility Maintenance/Operation and Pest Control

### 6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

WALL BEHIND SINK DAMAGED WITH DRYWALL EXPOSED. LAMINATE FLOOR BURNED AND CRACKED NEAR OVEN. EDGES OF CABINETRY SHELVING IS CHIPPING WITH EXPOSED WOOD MATERIAL.

*Comply By: 08/31/22*

---

| Total Orders | In This Report | Priority 1 | Priority 2 | Priority 3 |
|--------------|----------------|------------|------------|------------|
|              |                | 3          | 1          | 7          |

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH AN HRD SURVEY AT PARADISE CARE HOMES LLC, LOCATED AT 7709 UNITY AVE NORTH, BROOKLYN PARK, MN 55443. THE INSPECTION

WAS CONDUCTED IN THE PRESENCE OF AHMED MUSE, AND LESLIE HUNA, RN AND PERSON IN CHARGE. ALL ISSUES WERE DISCUSSED WITH LESLIE DURING AND AFTER THE INSPECTION. EMPLOYEE ILLNESS REPORTING AND EXCLUSION PROCEDURES WERE ALSO DISCUSSED.

KITCHEN: LAMINATE FLOOR, SMOOTH PAINTED WALLS, TEXTURED CEILING, LAMINATE COUNTER TOPS, WOOD/COMPOSITE CABINETRY AND SHELVING. KITCHEN IS NOT IN GOOD CONDITION.

THE IMPORTANCE OF SANITIZING WAS EMPHASIZED AND LESLIE WAS INSTRUCTED TO ADDRESS THE SANITIZING ISSUE IMMEDIATELY AND RE-WASH, RINSE, SANITIZE, AND AIR DRY ALL OF THE FOOD CONTACT DISHES AND UTENSILS.

ALL ISSUES WERE DISCUSSED WITH LEAD HRD SURVEYOR AND NURSING EVALUATOR, ASHLEY CREWS, RN, FOLLOWING THE INSPECTION.

Type: Full  
Date: 07/11/22  
Time: 11:00:50  
Report: 1029221210  
Paradise Care Homes Llc

# Food and Beverage Establishment Inspection Report

Page 4

**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 1029221210 of 07/11/22.

Certified Food Protection Manager LESLIE A. HUNA

Certification Number: FM108954 Expires: 12/22/24

Signed: \_\_\_\_\_

LESLIE HUNA  
RN

Signed:  \_\_\_\_\_

Trevor McCliment  
Public Health Sanitarian  
Metro District Office  
651-201-3957  
trevor.mccliment@state.mn.us

Report #: 1029221210

## Food Establishment Inspection Report



Minnesota Department of Health  
Food, Pools, and Lodging Services  
625 Robert Street North  
St. Paul

No. of RF/PHI Categories Out

5

Date 07/11/22

No. of Repeat RF/PHI Categories Out

0

Time In 11:00:50

Legal Authority MN Rules Chapter 4626

Time Out

Paradise Care Homes Lic

Address

7709 Unity Avenue North

City/State

Brooklyn Park, MN

Zip Code

55443

Telephone

6128596065

License/Permit #  
0037450

Permit Holder

Purpose of Inspection  
Full

Est Type

Risk Category

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT=not in compliance

N/O=not observed

N/A=not applicable

COS=corrected on-site during inspection

R=repeat violation

| Compliance Status                                                                         |                | COS | R |
|-------------------------------------------------------------------------------------------|----------------|-----|---|
| <b>Supervision</b>                                                                        |                |     |   |
| 1                                                                                         | IN OUT         |     |   |
| PIC knowledgeable; duties & oversight                                                     |                |     |   |
| 2                                                                                         | IN OUT N/A     |     |   |
| Certified food protection manager; duties                                                 |                |     |   |
| <b>Employee Health</b>                                                                    |                |     |   |
| 3                                                                                         | IN OUT         |     |   |
| Mgmt/Staff; knowledge, responsibilities & reporting                                       |                |     |   |
| 4                                                                                         | IN OUT         |     |   |
| Proper use of reporting, restriction & exclusion                                          |                |     |   |
| 5                                                                                         | IN OUT         |     |   |
| Procedures for responding to vomiting & diarrheal events                                  |                |     |   |
| <b>Good Hygienic Practices</b>                                                            |                |     |   |
| 6                                                                                         | IN OUT N/O     |     |   |
| Proper eating, tasting, drinking, or tobacco use                                          |                |     |   |
| 7                                                                                         | IN OUT N/O     |     |   |
| No discharge from eyes, nose, & mouth                                                     |                |     |   |
| <b>Preventing Contamination by Hands</b>                                                  |                |     |   |
| 8                                                                                         | IN OUT N/O     |     |   |
| Hands clean & properly washed                                                             |                |     |   |
| 9                                                                                         | IN OUT N/A N/O |     |   |
| No bare hand contact with RTE foods or pre-approved alternate procedure properly followed |                |     |   |
| 10                                                                                        | IN OUT         |     |   |
| Adequate handwashing sinks supplied/accessible                                            |                |     |   |
| <b>Approved Source</b>                                                                    |                |     |   |
| 11                                                                                        | IN OUT         |     |   |
| Food obtained from approved source                                                        |                |     |   |
| 12                                                                                        | IN OUT N/A N/O |     |   |
| Food received at proper temperature                                                       |                |     |   |
| 13                                                                                        | IN OUT         |     |   |
| Food in good condition, safe, & unadulterated                                             |                |     |   |
| 14                                                                                        | IN OUT N/A N/O |     |   |
| Required records available; shellstock tags, parasite destruction                         |                |     |   |
| <b>Protection from Contamination</b>                                                      |                |     |   |
| 15                                                                                        | IN OUT N/A N/O |     |   |
| Food separated and protected                                                              |                |     |   |
| 16                                                                                        | IN OUT N/A     |     |   |
| Food contact surfaces: cleaned & sanitized                                                |                |     |   |
| 17                                                                                        | IN OUT         |     |   |
| Proper disposition of returned, previously served, reconditioned, & unsafe food           |                |     |   |

| Compliance Status                                     |                | COS | R |
|-------------------------------------------------------|----------------|-----|---|
| <b>Time/Temperature Control for Safety</b>            |                |     |   |
| 18                                                    | IN OUT N/A N/O |     |   |
| Proper cooking time & temperature                     |                |     |   |
| 19                                                    | IN OUT N/A N/O |     |   |
| Proper reheating procedures for hot holding           |                |     |   |
| 20                                                    | IN OUT N/A N/O |     |   |
| Proper cooling time & temperature                     |                |     |   |
| 21                                                    | IN OUT N/A N/O |     |   |
| Proper hot holding temperatures                       |                |     |   |
| 22                                                    | IN OUT N/A     |     |   |
| Proper cold holding temperatures                      |                |     |   |
| 23                                                    | IN OUT N/A N/O |     |   |
| Proper date marking & disposition                     |                |     |   |
| 24                                                    | IN OUT N/A N/O |     |   |
| Time as a public health control: procedures & records |                |     |   |
| <b>Consumer Advisory</b>                              |                |     |   |
| 25                                                    | IN OUT N/A     |     |   |
| Consumer advisory provided for raw/undercooked food   |                |     |   |
| <b>Highly Susceptible Populations</b>                 |                |     |   |
| 26                                                    | IN OUT N/A     |     |   |
| Pasteurized foods used; prohibited foods not offered  |                |     |   |
| <b>Food and Color Additives and Toxic Substances</b>  |                |     |   |
| 27                                                    | IN OUT N/A     |     |   |
| Food additives: approved & properly used              |                |     |   |
| 28                                                    | IN OUT         |     |   |
| Toxic substances properly identified, stored, & used  |                |     |   |
| <b>Conformance with Approved Procedures</b>           |                |     |   |
| 29                                                    | IN OUT N/A     |     |   |
| Compliance with variance/specialized process/HACCP    |                |     |   |

**Risk factors (RF)** are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions (PHI)** are control measures to prevent foodborne illness or injury.

## GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R=repeat violation

| Compliance Status                                                       |                | COS | R |
|-------------------------------------------------------------------------|----------------|-----|---|
| <b>Safe Food and Water</b>                                              |                |     |   |
| 30                                                                      | IN OUT N/A     |     |   |
| Pasteurized eggs used where required                                    |                |     |   |
| 31                                                                      |                |     |   |
| Water & ice obtained from an approved source                            |                |     |   |
| 32                                                                      | IN OUT N/A     |     |   |
| Variance obtained for specialized processing methods                    |                |     |   |
| <b>Food Temperature Control</b>                                         |                |     |   |
| 33                                                                      |                |     |   |
| Proper cooling methods used; adequate equipment for temperature control |                |     |   |
| 34                                                                      | IN OUT N/A N/O |     |   |
| Plant food properly cooked for hot holding                              |                |     |   |
| 35                                                                      | IN OUT N/A N/O |     |   |
| Approved thawing methods used                                           |                |     |   |
| 36                                                                      |                |     |   |
| Thermometers provided & accurate                                        |                |     |   |
| <b>Food Identification</b>                                              |                |     |   |
| 37                                                                      |                |     |   |
| Food properly labeled; original container                               |                |     |   |
| <b>Prevention of Food Contamination</b>                                 |                |     |   |
| 38                                                                      |                |     |   |
| Insects, rodents, & animals not present                                 |                |     |   |
| 39                                                                      |                |     |   |
| Contamination prevented during food prep, storage & display             |                |     |   |
| 40                                                                      |                |     |   |
| Personal cleanliness                                                    |                |     |   |
| 41                                                                      | X              |     |   |
| Wiping cloths: properly used & stored                                   |                |     |   |
| 42                                                                      |                |     |   |
| Washing fruits & vegetables                                             |                |     |   |

| Compliance Status                                                                  |   | COS | R |
|------------------------------------------------------------------------------------|---|-----|---|
| <b>Proper Use of Utensils</b>                                                      |   |     |   |
| 43                                                                                 |   |     |   |
| In-use utensils: properly stored                                                   |   |     |   |
| 44                                                                                 |   |     |   |
| Utensils, equipment & linens: properly stored, dried, & handled                    |   |     |   |
| 45                                                                                 |   |     |   |
| Single-use/single service articles: properly stored & used                         |   |     |   |
| 46                                                                                 |   |     |   |
| Gloves used properly                                                               |   |     |   |
| <b>Utensil Equipment and Vending</b>                                               |   |     |   |
| 47                                                                                 | X |     |   |
| Food & non-food contact surfaces cleanable, properly designed, constructed, & used |   |     |   |
| 48                                                                                 |   |     |   |
| Warewashing facilities: installed, maintained, & used; test strips                 |   |     |   |
| 49                                                                                 |   |     |   |
| Non-food contact surfaces clean                                                    |   |     |   |
| <b>Physical Facilities</b>                                                         |   |     |   |
| 50                                                                                 |   |     |   |
| Hot & cold water available; adequate pressure                                      |   |     |   |
| 51                                                                                 |   |     |   |
| Plumbing installed; proper backflow devices                                        |   |     |   |
| 52                                                                                 |   |     |   |
| Sewage & waste water properly disposed                                             |   |     |   |
| 53                                                                                 |   |     |   |
| Toilet facilities: properly constructed, supplied, & cleaned                       |   |     |   |
| 54                                                                                 |   |     |   |
| Garbage & refuse properly disposed; facilities maintained                          |   |     |   |
| 55                                                                                 | X |     |   |
| Physical facilities installed, maintained, & clean                                 |   |     |   |
| 56                                                                                 |   |     |   |
| Adequate ventilation & lighting; designated areas used                             |   |     |   |
| 57                                                                                 |   |     |   |
| Compliance with MCIAA                                                              |   |     |   |
| 58                                                                                 |   |     |   |
| Compliance with licensing & plan review                                            |   |     |   |

Food Recalls:

Person in Charge (Signature)

Date: 07/13/22

Inspector (Signature)