Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF PROVISIONAL CONDITIONAL LICENSE

Electronic Delivery

January 21, 2025

Licensee
Bloomington Home Health
8325 Oakland Avenue South
Bloomington, MN 55420

RE: Initial License Number 412911
Health Facility Identification Number (HFID) 40198
Project Number(s) SL40198015

Dear Licensee:

On January 14, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed October 22, 2024. The follow-up survey found the facility to be in substantial compliance . Based on these findings, the condition(s) on the license were removed effective January 21, 2025.

Effective, January 21, 2024 MDH is granting your Assisted Living Facility license. Your license effective and expiration dates remain the same as on your provisional license. Your license number is 412911. You will not receive a replacement license certificate until your license is due to renew. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at: Health.assistedliving@state.mn.us.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

November 27, 2024

Licensee
Bloomington Home Health
8325 Oakland Avenue South
Bloomington, MN 55420

RE: Provisional Conditional License Number 412911
Health Facility Identification Number (HFID) 40198
Project Number(s) SL40198015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 22, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **February 25, 2025**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

CONDITIONAL LICENSE ISSUED:

MDH will issue Bloomington Home Health a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Bloomington Home Health is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **General Contractor:** Bloomington Home Health must provide the following to Benjamin J. Zwart (Benjamin.Zwart@state.mn.us) via email within 21-days of the date of this notice:
    i. Name
    ii. License Number
    iii. Contact Information

b. **Egress Window Requirements:** Bloomington Home Health will replace at least one window in occupied resident sleeping rooms #1, #2, and #3 meeting the minimum size requirements.
    i. Must have a minimum openable width of no less than 20 inches
    ii. Must have a minimum openable height of no less than 20 inches
    iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
    iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
    v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

c. **Corrective Action Plan:** Bloomington Home Health will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if Bloomington Home Health is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Bloomington Home Health is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Bloomington Home Health. If MDH determines Bloomington Home Health is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

If you have any questions, please contact Benjamin J. Zwart directly at: 651-201-3715.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40198	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON HOME HEALTH	8325 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40198015-0 On October 21, 2024, through October 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 2 resident(s); 2 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 22, 2024 for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each	0 630		

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0 630	Continued From page 2 vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: R2 R2 was admitted to the licensee on October 4, 2023. R2's IAPP dated September 16, 2024, indicated R2 was not at risk to be abused and not at risk of abusing others but did not include: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	0 630		

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0 630	Continued From page 3 R3 R3 was admitted to the licensee on July 3, 2024. R3's IAPP dated October 11, 2024, indicated R3 was not at risk to be abused and not at risk of abusing others but did not include: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On October 22, 2024, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated she missed putting in specific interventions to minimize the risk for abuse. The licensee's Vulnerable Adult Policy dated April 3, 2023, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. - The plan shall contain an individualized assessment of the resident' susceptibility to abuse by another individual, including other vulnerable adults; - The plan shall contain the resident's risk of abusing other vulnerable adults; - The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults; and - The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 780	Continued From page 4	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 5 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on October 22, 2024, from 9:30 a.m. to 10:15 a.m., with owner (O)-B, and clinical nurse supervisor (CNS)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code: USED CIGARETTE BUTT DISPOSAL There was used cigarette butts disposed on the ground and next to the building around the front deck and ramp and around the back deck. Used cigarette butts are required to be disposed of in an approved dispenser in accordance with the facility smoking policy. MARKED EXIT DOORS There was an exit sign above the sliding patio door leading to the back deck directing occupants through that door as an exit. Marked exit doors are required to be of the side hinge swinging type and not sliding doors. The door leading from the basement of the assisted living into the garage was marked with an exit sign leading occupants through the garage as an exit. The door leading from the assisted living to the garage shall not be marked as an exit and lead occupants through the garage as an exit as the garage is a higher hazard area than the assisted living area.	0 780		

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0 780	Continued From page 6 The back patio door and the door leading to the garage from the basement of the assisted living were marked on the evacuation floor plan as exits. The sliding patio door and the door leading through the garage area as an exit are not compliant exit doors in accordance with the requirements of the Minnesota State Fire Code. GARAGE/ ASSISTED LIVING FIRE-RESISTANT SEPARATION The fire-resistant wall separating the attached garage from the assisted living had a whole cut through near the top of the wall above the floor of the attic. The fire-resistant wall between the house and garage is required to be maintained with minimum ½ inch tightly fit drywall membrane on the garage side of the wall. INTERIOR GATES There was a gate installed at the top of the basement stairs that would not open fully to allow unobstructed travel through the interior path of egress to the exit. During the facility tour O-B, and CNS-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 7 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 8 violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 22, 2024, at 9:00 a.m., owner (O)-B, and clinical nurse supervisor (CNS)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year in addition to during onboarding as evident by providing documentation employee training was provided once in 2023 only. No employee training documentation was provided for 2024. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the resident training was provided as required. During an interview on October 22, 2024, at 9:10 a.m., O-B, and CNS-A, stated documentation was not available for completion of training for employees twice per year and provided training for residents once per year. DRILLS	0 810		

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0 810	Continued From page 9 Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed February 7, 2024, March 22, 2024, June 12, 2024, August 14, 2024, and October 21, 2024, only. No documentation was available for drills completed during the overnight shift in 2024. During an interview on October 22, 2024, at 9:25 a.m., CNS-A, stated documentation was not available for drills completed during the overnight shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	0 820		

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0 820	Continued From page 10 Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On a facility tour on October 22, 2024, from 9:30 a.m. to 10:15 a.m., with owner (O)-B, and clinical nurse supervisor (CNS)-A, the following distinct hazards were observed: EMERGENCY ESCAPE AND RESCUE WINDOWS The emergency escape and rescue window clear openings in resident sleeping rooms 1 and 2, measured 20 inches wide, 34 inches high, and 680 square inches in openable area. The storm window installed on the exterior separate from the window frame reduced the clear opening width to 19.25 inches. During the tour O-B, and CNS-A, stated the storm windows will be removed from the exterior of the window frame on one window in sleeping rooms 1 and 2. These deficient conditions were visually verified by O-B, and CNS-A, accompanying on the tour.	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40198	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON HOME HEALTH	8325 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 11 TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (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 (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. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the service plan included	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40198	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON HOME HEALTH	8325 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 12 the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on October 4, 2023. R2's service plan dated October 4, 2023, indicated R2 received the following services: dressing, grooming, bathing, toileting, meals, verbal medication reminders, weekly med setup, laundry, and housekeeping. R2's service plan lacked the following required content: - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B,145C, and declarations made by the resident under those chapters.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40198	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON HOME HEALTH	8325 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 13 On October 22, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-A stated she missed filling out the contingency portion of the paper service plan that was used for R2 but the licensee is in the process of switching from paper to electronic charting and she had meant to print out a new service plan for R2 to sign but had forgotten to do so. The licensee's Service Plan policy dated April 3, 2023, indicated the the service plan includes the following: a contingency plan that includes: - action to be taken if scheduled services cannot be provided; - information and method for a resident or resident's representative to contact the facility; - the names and contact information the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition; - the identification of and information as to who has the authority to sign for the resident in an emergency; and - circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to healthcare directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40198	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON HOME HEALTH	8325 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 14 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 24, 2024, at 10:00 a.m., the surveyor observed unlicensed personnel (ULP)-C obtain a set of keys from owner (O)-B for the locked medication cabinet which was located in the living room. The surveyor observed ULP-C use the keys to gain access to the medication cabinet which held the residents' medications. ULP-C obtained medications from the cabinet for administration to R3, closed the medication cabinet drawer, left the keys in the lock, and proceeded to leave the living room. Clinical nurse supervisor (CNS)-A, that was in the same living room, advised ULP-C to take the keys with her and not leave them in the cabinet. ULP-C stated she would be right back for the keys as she proceeded down the hall to R3's bedroom. ULP-C administered R3's medications and returned to the living room and took the keys out of the	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40198	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON HOME HEALTH	8325 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

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01880	Continued From page 15 medication cabinet lock. On October 24, 2024, at 10:15 a.m., ULP-C stated the keys were left in the cabinet because no other residents were in the living room. On October 24, 2024, at 3:20 p.m., CNS-A stated she would expect the staff to keep the keys secured and not leave them in the medication cabinet unattended. The licensee's Storage /Control of Medication policy dated April 3, 2023, indicated when licensee is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in some substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/22/24*
Time: 10:23:46
Report: 8044241327

Food and Beverage Establishment Inspection Report

Location:
Bloomington Home Health
8325 Oakland Ave S
Bloomington, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0043687
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Milk in refrigerator measured at 45 degrees F.

Unit temperature turned down while on site.
Comply By: 10/22/24

4-200 Equipment Design and Construction
4-203.12 ***** Priority 2 *****
MN Rule 4626.0560 Replace ambient air and water temperature measuring devices that are not accurate to plus or minus 3 degrees F.

Built in thermometer for refrigerator is not accurate. Provide a new thermometer.
Comply By: 10/22/24

Surface and Equipment Sanitizers

Chlorine: = at 160.0 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41.5 Degrees Fahrenheit - Location: Hot dogs in fridge
Violation Issued: No

Type: Full
Date: *10/22/24*
Time: 10:23:46
Report: 8044241327
Bloomington Home Health

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 45.2 Degrees Fahrenheit - Location: Milk in fridge
Violation Issued: No

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

HRD inspection conducted with nurse evaluator Sarabeth Remker. Report reviewed on site with Mohamed.

Domestic kitchen consists of painted gypsum ceilings, tile walls, wood floors, wooden hollow base cabinets, laminate counters, and domestic equipment including a dishwasher.

Establishment Info: bloomingtonhomehealth@gmail.com

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 8044241327 of 10/22/24.

Certified Food Protection Manager: Abdulrahman Said Mohamed

Certification Number: FM122827 Expires: 04/17/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Abdul

Signed: _____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us