DEPARTMENT OF HEALTH

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

**NOTICE OF REMOVAL OF CONDITIONAL LICENSE**

Electronic Delivery

February 2, 2023

Licensee
Bright Side Healthcare, LLC
6907 Perry Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 405368
Health Facility Identification Number (HFID) 37859
Project Number(s) SL37859015

Dear Licensee:

On January 19, 2023, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your agency to determine correction of orders found on the licensing evaluation completed on October 5, 2022. The follow-up evaluation found the agency to be in substantial compliance. Based on these findings, the condition(s) on the Provisional Assisted Living Facility license were removed effective January 19, 2023.

Effective January 19, 2023, MDH is granting your Assisted Living Facility license. If you have not received a letter from us with information regarding renewing your license within 45 days from the date of this letter, please contact us at (651) 201-5273 or by email at: Health.Homecare@state.mn.us.

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 Carrie Euerle at 651-201-5984,

Sincerely,

Maria King

Maria King, RN
**Division Director**
**Minnesota Department of Health**
**Health Regulation Division**
PMB

DEPARTMENT OF HEALTH

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

**NOTICE OF EXTENSION OF PROVISIONAL LICENSE**
**CONDITIONAL LICENSE ISSUED**

Electronically Delivered

October 19, 2022

Administrator
Bright Side Healthcare, LLC
6907 Perry Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 405368
Health Facility Identification Number (HFID) 37859
Project Number(s) SL37859015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on October 5, 2022 for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

Pursuant to Minn. Stat. § 144G.16, Subd. 3 (b), if a provisional licensee is not in substantial compliance with the initial survey, the commissioner shall either: (1) not issue the facility license and terminate the provisional license; or (2) extend the provisional license for a period not to exceed 45 calendar days and apply conditions necessary to bring the facility into substantial compliance. If the provisional licensee is not in substantial compliance with the survey within the period of the extension, or if the provisional licensee does not satisfy the license conditions, the commissioner may deny the license.

Based on the findings of the October 5, 2022, survey, your provisional assisted living facility license is extended for a period of 90 calendar days and conditions are imposed.

As a result, MDH is issuing a 90 day conditional license due to expire on January 17, 2023.

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 - 0180 - 144g.16 Subd. 2 - Initial Survey = $3,000**
**St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements = $3,000**

**The total amount you are assessed is $6,000**. 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:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should 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

**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.

**Conditional License Issued:**
MDH will issue Bright Side Healthcare, LLC a conditional 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 evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Bright Side Healthcare, LLC is in compliance.

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Bright Side Healthcare, LLC will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Bright Side Healthcare, LLC must provide the Department:

    i. A list of the names and birthdates of any individuals Bright Side Healthcare, LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Bright Side Healthcare, LLC will contract with an RN to provide consultation concerning all resident(s) to whom Bright Side Healthcare, LLC provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Bright Side Healthcare, LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Bright Side Healthcare, LLC and MDH must review the RN's credentials and approve the selection. Bright Side Healthcare, LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Bright Side Healthcare, LLC in an effort to help Bright Side Healthcare, LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Bright Side Healthcare, LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

**d. Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Bright Side Healthcare, LLC and the RN consultant about a change. Each report will be electronically submitted to Carrie Euerle, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at carrie.euerle@state.mn.us. Carrie Euerle can be reached at (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

**e. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Bright Side Healthcare, LLC to correct the violations cited during the evaluation as well as to determine the overall practice of Bright Side Healthcare, LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

**f. Follow-up Evaluation:** At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

**g. Corrective Action Plan:** Bright Side Healthcare, LLC 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 compliance for each corrected order

**Results of Follow-Up Survey During the Conditional License Period:**
MDH will determine if Bright Side Healthcare, LLC is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Bright Side Healthcare, LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Bright Side Healthcare, LLC's assisted living facility license, and Bright Side Healthcare, LLC will correct violations identified during the evaluation to come into full compliance. If MDH determines Bright Side Healthcare, LLC is not in substantial compliance, MDH may take additional enforcement action against Bright Side Healthcare, LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

**Request a Hearing:**
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing 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
**Health.HRD.Appeals@state.mn.us**

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Carrie Euerle directly at: 651-201-5984.

Sincerely,

Maria King, RN
**Division Director**

**Minnesota Department of Health**
**Health Regulation Division**

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37859 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL37859015<br><br>On October 4, 2022 through October 5, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents, all of whom received services, under the provider's provisional Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 110 SS=F | 144G.10 Subdivision 1a Assisted living director license required | 0 110 | | |

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| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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| 0 110 | Continued From page 1<br>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD) had approval by the Board of Executives for Long Term Services and Supports (BELTSS) for a shared director license. This had the potential to affect all residents residing at the assisted living facility.<br><br>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).<br><br>The findings include:<br><br>On October 3, 2022, at 11:20 a.m., a photocopy of LALD-A's license was observed in the living room of the facility.<br><br>On October 3, 2022, at 11:40 a.m., the BELTSS website was reviewed for verification of LALD-A's assisted living director licensure. LALD-A was listed as having a current LALD license and overseeing four (4) facilities; five (5) is the maximum one director can oversee.<br><br>On October 3, 2022, at 11:45 a.m., LALD-A stated he had a photocopy of his license posted | 0 110 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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| 0 110 | Continued From page 2<br><br>because the original was posted at another location he oversees. LALD-A was not aware an original license must be posted. LALD-A stated he was allowed to oversee multiple sites. LALD-A confirmed he was not aware he needed approval from BELTSS to obtain a shared director license. A copy of the licensee's shared director plan was requested. LALD-A stated he did not know what that was and did not have a plan established.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 110 | | |
| 0 180 SS=I | 144G.16 Subd. 2 Initial survey<br><br>(a) During the provisional license period, the commissioner shall survey the provisional licensee after the commissioner is notified or has evidence that the provisional licensee is providing assisted living services to at least one resident.<br>(b) Within two days of beginning to provide assisted living services, the provisional licensee must provide notice to the commissioner that it is providing assisted living services by sending an e-mail to the e-mail address provided by the commissioner.<br>(c) If the provisional licensee does not provide services during the provisional license period, the provisional license shall expire at the end of the period and the applicant must reapply.<br>(d) If the provisional licensee notifies the commissioner that the licensee is providing assisted living services within 45 calendar days prior to expiration of the provisional license, the commissioner may extend the provisional license for up to 60 calendar days in order to allow the commissioner to complete the on-site survey | 0 180 | | |

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| 0 180 | Continued From page 3<br>required under this section and follow-up survey visits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to notify the Minnesota Department of Health (MDH) within two days of starting services. This had the potential to affect all residents residing at the assisted living facility.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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).<br><br>Findings Include:<br><br>MDH records indicated the licensee informed MDH of initiation of assisted living services on May 17, 2022. The notification of providing assisted living services document sent to MDH indicated assisted living services started on December 1, 2021.<br><br>On October 3, 2022, at 4:45 p.m., licensed assisted living director (LALD)-A stated they forgot to notify MDH in December and didn't notice they had not reported they started services until May 17, 2022.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) Days | 0 180 | | |

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| 0 250 SS=F | 144G.20 Subdivision 1 Conditions<br><br>(a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:<br>(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;<br>(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;<br>(3) performs any act detrimental to the health, safety, and welfare of a resident;<br>(4) obtains the license by fraud or misrepresentation;<br>(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;<br>(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;<br>(7) interferes with or impedes a representative of the department in contacting the facility's residents;<br>(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;<br>(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;<br>(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;<br>(11) refuses to initiate a background study under | 0 250 | | |

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| 0 250 | Continued From page 5<br>section 144.057 or 245A.04;<br>(12) fails to timely pay any fines assessed by the commissioner;<br>(13) violates any local, city, or township ordinance relating to housing or assisted living services;<br>(14) has repeated incidents of personnel performing services beyond their competency level; or<br>(15) has operated beyond the scope of the assisted living facility's license category.<br>(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. Additionally, the licensee failed to provide a representative of the department access to current facility records and impeded the follow up survey by failing to fully cooperate with the survey. This had the potential to affect all residents, staff and visitors.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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). | 0 250 | | |

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| 0 250 | Continued From page 6<br>The findings include:<br><br>The licensee's Application for Assisted Living Provisional License, section titled Official Verification of Owner or Authorized Agent, (page 16 and 17 of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:<br><br>- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.<br><br>- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.<br><br>- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.<br><br>- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.<br><br>- Reporting of Maltreatment of Vulnerable Adults.<br><br>- Electronic Monitoring in Certain Facilities.<br><br>- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the | 0 250 | | |

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| | 37859 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

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| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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| 0 250 | Continued From page 7<br>requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.<br><br>- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.<br><br>- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.<br><br>- I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of | 0 250 | | |

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| 0 250 | Continued From page 8<br>my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.<br><br>- I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.<br><br>Page 17 was electronically signed by LALD-A on July 9, 2021.<br><br>The licensee had a provisional assisted living license issued on November 17, 2021 , with an expiration date of November 16, 2022.<br><br>The licensee failed to ensure the following policies and procedures were developed and/or implemented:<br>- orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; and<br>- medication and treatment management<br><br>On October 3, 2022, at approximately 4:50p.m., licensed assisted living director (LALD)-A confirmed the licensee provided Assisted living services but failed to implement corresponding policies and procedures, as required.<br><br>As a result of this survey, the following orders were issued 0110, 0180, 0250, 0450, 0480, 0485, 0495, 0630, 0680, 0720, 0790, 0800, 0810, 0970, 1470, 1610, 1620,1640, 1750, 1760, 1820, 2290, 2400, 2430, 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. | 0 250 | | |

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| 0 250 | Continued From page 9<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 250 | | |
| 0 450 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>All assisted living facilities shall:<br>(1) distribute to residents the assisted living bill of rights;<br>(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;<br>(3) utilize a person-centered planning and service delivery process;<br>(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interviews and record review, the licensee failed to ensure person-centered service delivery for two of two residents (R1, R3) reviewed.<br><br>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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). | 0 450 | | |

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| 0 450 | Continued From page 10<br><br>The findings include:<br><br>R1<br>R1 admitted to the facility December 1, 2021.<br><br>R1's diagnoses included anxiety, type two diabetes, and chronic pain.<br><br>R1's service plan, dated December 21, 2021, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, medication administration, three times per day wellness check, housekeeping, and laundry.<br><br>R1's Individual Abuse Prevention Plan (IAPP), dated September 14, 2022, indicated the resident was not susceptible to abuse from other residents and was able to report abuse or neglect.<br><br>On October 3, 2022, at 2:15 p.m., R1 stated she had reported a number of concerns to management and did not feel they had been addressed properly. R1 stated there was a resident in the facility who would frequently yell at others and call herself and other residents "fuckers." R1 reported R3 is very hostile and has gotten up in her face and yelled profanities at her. R1 stated this behavior has made her feel not safe and she has reported that concern to management. R1stated the resident's room is above hers and he will frequently be up at all hours of the night and it will keep her awake. R1 stated management has told her R3 "has issues" and there isn't much they can do.<br><br>On October 3, 2022, at 2:40 p.m., licensed assisted living director (LALD)-A confirmed he was aware of ongoing "verbal altercations" | 0 450 | | |

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| 0 450 | Continued From page 11 | 0 450 | | |

between residents at the facility and confirmed he was aware R3 would call R1 and others "fuckers" and other inappropriate words. LALD-A stated he felt since there was no physical altercations, the verbal altercations were not a big deal. LALD-A stated the residents usually get over it quickly and they didn't think it was an issue. LALD-A stated he was not aware R1 did not feel safe as a result of the verbal altercations.

On October 3, 2022, at 2:45 p.m., assistant director (AD)-B stated R3's communication style is verbally aggressive and sometimes he will shout and scream at other residents. AD-B confirmed staff did not have any interventions listed on either resident's Individual Abuse Prevention Plan and they just let the residents work it out among themselves.

R3
R3 admitted to the facility August 2, 2022.

R3's diagnoses included attention deficit disorder, bipolar disorder, and delusion disorder.

R3's service plan, dated August 2, 2022, indicated the resident received the following services: assistance with toileting, bathing, medication administration, assistance with eating, three times per day wellness check, housekeeping, and laundry.

R3's IAPP, dated August 16, 2022, indicated the resident's environment was always safe and clean, and the resident was not at risk of abusing other vulnerable adults.

R3's assessment, dated August 2, 2022, did not indicate any concerns with hoarding or inability to keep his room free from clutter. The assessment

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| 0 450 | Continued From page 12<br>did not address R3's history of verbal altercations with other residents.<br><br>On October 3, 2022, at 2:00 p.m., the resident's room was observed with R3 and LALD-A present. R3's room was observed to be cluttered with various personal items covering most of the floor of the room. Stacks of items reached approximately two to three feet tall. A small path had been cleared for the resident to walk across the room to his bed and bathroom. The resident's bathroom was observed to be cluttered, with various bottles of cleaning supplies throughout the bathroom. A fitted bed sheet was observed on the bed and appeared to be wrinkled and dirty. Bags of garbage were observed in the room. R3 stated staff usually did not clean his room. LALD-A stated the resident had a history of hoarding and he frequently refused to allow staff to clean his room. LALD-A was unable to produce documentation to show the resident's refusals.<br><br>On October 3, 2022, at 2:05 p.m., assistant director (AD)-B and unlicensed personnel (ULP)-D were observed picking up R3's room. R3 expressed his anger and frustration and stated he did not want staff to clean out his room without his permission.<br><br>On October 3, 2022, at 2:50 p.m., LALD-A stated the facility was aware R3 had a history of hoarding and having a messy room. LALD-A confirmed the facility had not identified this on his assessments or IAPP and did not have appropriate interventions in place to ensure the resident's rights were honored while also ensuring he remains safe in his room. LALD-A confirmed other residents had made complaints about R3's behaviors and hoarding. | 0 450 | | |

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| 0 450 | Continued From page 13<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 450 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all four current residents.<br><br>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 | 0 480 | | |

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| 0 480 | Continued From page 14<br>was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:<br><br>Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated October 4, 2022.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 485 SS=F | 144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(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;<br><br>(C) the facility cannot require a resident to include and pay for meals in their contract; | 0 485 | | |

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| 0 485 | Continued From page 15<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. This had the potential to affect all residents.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on October 4, 2022, at 11:40 a.m., assistant director (AD)-B stated the facility served three meals per day that followed USDA guidelines. AD-B stated the residents had a late breakfast so they likely would not be having lunch today.<br><br>On October 4, 2022, at 12:15 p.m., the surveyor observed lunch had not been prepared for the residents. During continuous observations from 12:15 p.m. to 5:00 p.m., two residents were observed microwaving their own food to eat for lunch. Two other residents were not observed to eat anything for lunch. No snacks were observed to be offered to the facility's four residents and no snack option was listed on the menu. On October 4, 2022, at 5:00 p.m., they surveyor observed the facility staff prepare and serve supper to the | 0 485 | | |

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| 0 485 | Continued From page 16<br>residents.<br><br>During resident interviews on October 4, 2022, several residents interviewed stated meals could be unpredictable and might not be prepared when they are scheduled to be prepared. Several residents stated they weren't able to get meals at times that were convenient for them or would have to make meals on their own. Several residents expressed a preference that the facility would prepare and serve meals as scheduled versus have them make their own food or figure out what they wanted to eat.<br><br>In addition, the licensee's menu contained several days where USDA guidelines were not followed.<br><br>One day of planned meals included the following:<br>omlettes with sausage and cheese, breakfast potatoes<br>hot dogs, baked beans, chips<br>chicken patties, side salad with veggies<br><br>Another day of planned meals included the following:<br>scrambled eggs, hashbrowns, sausage links<br>tuna pasta salad, pickle spear, chips<br>ribs, baked potato, coleslaw<br><br>On October 4, 2022, at 2:50 p.m., licensed assisted living director (LALD)-A confirmed the menu did not follow My Plate guidelines.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |

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| 0 495 | Continued From page 17 | 0 495 | | |
| 0 495 SS=I | 144G.41 Subd. 1 (14) Minimum Requirements<br><br>(14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, the licensee failed to ensure staff had access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This affected all residents and staff.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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).<br><br>Findings include:<br><br>On October 3, 2022, at 11:20 a.m., the surveyor requested to speak with the licensee's RN. Unlicensed personnel (ULP)-C stated she wasn't sure where the RN was or when she would be coming in. ULP-C was unsure of what the RN's name was but was able to locate a phone number to contact the RN. ULP-C was unable to reach the RN via phone.<br><br>Two residents in the common area of the facility stated the RN was not usually at the facility and both stated they had a difficult time contacting the RN regarding concerns. R2 stated the RN appeared to be "worn thin bouncing between facilities." | 0 495 | | |

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| 0 495 | Continued From page 18<br><br>On October 3, 2022, at 11:45 a.m., licensed assisted living director (LALD)-A attempted to contact the RN. LALD-A stated the RN works for another company and was not available. LALD-A stated the RN also covers for this facility and another one operated by him.<br><br>On October 3, 2022, at 1:30 p.m., LALD-A stated the RN would be coming to the facility shortly. LALD-A stated the nurse had been in a meeting with a resident at the other company she worked for so he had not been able to reach her for a few hours.<br><br>On October 3, 2022, at 2:30 p.m., LALD-A confirmed residents had voiced complaints about not being able to get ahold of the RN in a timely manner. LALD-A stated the nurse would try to respond when she's able to. LALD-A stated if there was an issue that the RN needed to respond to immediately or come on site for, he thought her other job would allow her to leave and come here but he wasn't able to say for sure if they'd let her or not.<br><br>On October 3, 2022, at 2:45 p.m., RN-C stated she's usually always available but had been participating in a care conference with a resident at her other job so was not able to take a call or meet with the surveyor until that had finished.<br><br>The licensee's policy, 6.12 Availability of an RN for Staff, dated August 1, 2021, indicated the licensee would have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. The RN must be readily available | 0 495 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37859 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 495 | Continued From page 19<br>either in person, by telephone, or by other means to the staff at times when the staff is providing services.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 0 495 | | |
| 0 630 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:<br>Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include all required content and accurately reflected areas of vulnerabilities for two of two residents (R1, R3) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all | 0 630 | | |

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| 0 630 | Continued From page 20<br>of the residents).<br><br>The findings include:<br><br>R1<br>R1 admitted to the facility December 1, 2021.<br><br>R1's diagnoses included anxiety, type two diabetes, and chronic pain.<br><br>R1's service plan, dated December 21, 2021, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, medication administration, three times per day wellness check, housekeeping, and laundry.<br><br>R1's Individual Abuse Prevention Plan (IAPP), dated September 14, 2022, indicated the resident was not susceptible to abuse from other residents and was able to report abuse or neglect, and indicated the resident was not at risk for self abuse.<br><br>R1's record included a No Suicide Contract, dated December 1, 2021. The contract had the resident agree to not harm themselves or attempt suicide. The contract had the resident agree to "get rid of anything that I could use to kill myself, including but not limited to, guns, weapons, or pills." By signing the required contract, the resident agreed the conditions outlined were a part of their assisted living contract and was effective immediately and indefinitely.<br><br>On October 3, 2022, at 2:15 p.m., R1 stated she had reported a number of concerns to management and did not feel they had been addressed properly. R1 stated there was a resident in the facility who would frequently yell at | 0 630 | | |

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| 0 630 | Continued From page 21<br><br>others and call herself and other residents "fuckers." R1 reported R3 is very hostile and has gotten up in her face and yelled profanities at her. R1 stated this behavior has made her feel not safe and she has reported that concern to management. R1stated the resident's room is above hers and he will frequently be up at all hours of the night and it will keep her awake. R1 stated management has told her R3 "has issues" and there isn't much they can do.<br><br>On October 3, 2022, at 2:40 p.m., licensed assisted living director (LALD)-A confirmed he was aware of ongoing "verbal altercations" between residents at the facility and confirmed he was aware R3 would call R1 and others "fuckers" and other inappropriate words. LALD-A stated he felt since there was no physical altercations, the verbal altercations were not a big deal. LALD-A stated the residents usually get over it quickly and they didn't think it was an issue. LALD-A stated he was not aware R1 did not feel safe as a result of the verbal altercations.<br><br>On October 3, 2022, at 2:45 p.m., assistant director (AD)-B stated R3's communication style is verbally aggressive and sometimes he will shout and scream at other residents. AD-B confirmed staff did not have any interventions listed on either resident's Individual Abuse Prevention Plan and they just let the residents work it out among themselves.<br><br>On October 3, 2022, at 4:45 p.m., RN-C confirmed the IAPP for R1 was not accurate or reflected the resident's current vulnerabilities. RN-C stated the resident was not at risk for self harm but they had been advised to have all residents sign a no suicide contract as a condition of admission. RN-C confirmed R1 was | 0 630 | | |

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| 0 630 | Continued From page 22<br>susceptible to abuse from other residents and appropriate interventions had not been put in place.<br><br>R3<br>R3 admitted to the facility August 2, 2022.<br><br>R3's diagnoses included attention deficit disorder, bipolar disorder, and delusion disorder.<br><br>R3's service plan, dated August 2, 2022, indicated the resident received the following services: assistance with toileting, bathing, medication administration, assistance with eating, three times per day wellness check, housekeeping, and laundry.<br><br>R3's IAPP, dated August 16, 2022, indicated the resident was not at risk for self abuse, the resident's environment was always safe and clean, and the resident was not at risk of abusing other vulnerable adults.<br><br>R3's assessment, dated August 2, 2022, did not indicate any concerns with hoarding or inability to keep his room free from clutter. The assessment did not address R3's history of verbal altercations with other residents.<br><br>R3's record included a No Suicide Contract, dated August 2, 2022. The contract had the resident agree to not harm themselves or attempt suicide. The contract had the resident agree to "get rid of anything that I could use to kill myself, including but not limited to, guns, weapons, or pills." By signing the required contract, the resident agreed the conditions outlined were a part of their assisted living contract and was effective immediately and indefinitely. | 0 630 | | |

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| 0 630 | Continued From page 23<br><br>On October 3, 2022, at 2:00 p.m., the resident's room was observed with R3 and LALD-A present. R3's room was observed to be cluttered with various personal items covering most of the floor of the room. Stacks of items reached approximately two to three feet tall. A small path had been cleared for the resident to walk across the room to his bed and bathroom. The resident's bathroom was observed to be cluttered, with various bottles of cleaning supplies throughout the bathroom. A fitted bed sheet was observed on the bed and appeared to be wrinkled and dirty. Bags of garbage were observed in the room. R3 stated staff usually did not clean his room. LALD-A stated the resident had a history of hoarding and he frequently refused to allow staff to clean his room. LALD-A was unable to produce documentation to show the resident's refusals.<br><br>On October 3, 2022, at 2:05 p.m., assistant director (AD)-B and unlicensed personnel (ULP)-D were observed picking up R3's room. R3 expressed his anger and frustration and stated he did not want staff to clean out his room without his permission.<br><br>On October 3, 2022, at 2:50 p.m., LALD-A stated the facility was aware R3 had a history of hoarding and having a messy room. LALD-A confirmed the facility had not identified this on his assessments or IAPP and did not have appropriate interventions in place to ensure the resident's rights were honored while also ensuring he remains safe in his room. LALD-A confirmed other residents had made complaints about R3's behaviors and hoarding.<br><br>On October 3, 2022, at 4:50 p.m., RN-C confirmed the IAPP for R3 was not accurate or | 0 630 | | |

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| 0 630 | Continued From page 24<br>reflected the resident's current vulnerabilities. RN-C stated the resident was not at risk for self harm but they had been advised to have all residents sign a no suicide contract as a condition of admission. RN-C confirmed R3 had a history of verbal outbursts towards others and a history of hoarding that had not been appropriately assessed.<br><br>The licensee's 6.05 Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the licensee would develop and implement an IAPP for each vulnerable adult. The plan would 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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 680 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; | 0 680 | | |

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| 0 680 | Continued From page 25<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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have a written emergency disaster plan with all required content as defined in Appendix Z. This had the potential to affect all residents receiving assisted living services, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On October 3, 2022 at 11:30 a.m., a request was made to view the licensee's emergency | 0 680 | | |

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| 0 680 | Continued From page 26<br>preparedness plan, which was later reviewed by the surveyor.<br><br>The plan contained a binder of various emergency situations, including how staff should respond. The licensee's policies included direction on making an emergency plan, and the policies listed various emergency situations (such as heat, several weather emergencies, emergency evacuations, plan activations); however, the procedures spelled out in the plan were generic, lacking specificity to the licensee.<br><br>The licensee's plan lacked the following required content:<br>-an assessment of the at-risk population's needs;<br>-a process for emergency preparedness (EPS) cooperation with state and local emergency preparedness (EP) officials/organizations;<br>-subsistence needs for staff and residents during emergency situation;<br>-procedure for tracking staff and residents;<br>-development of all policies and procedures, based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents and how the facility will provide care under an 1135 waiver declared by the Secretary;<br>-transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; and<br><br>On October 3, 2022, at 11:45 a.m., assistant director (AD)-B stated she was not familiar with the licensee's emergency plan and the registered nurse (RN) would be the one who is most familiar with it.<br><br>On October 3, 2022, at 2:30 p.m., licensed | 0 680 | | |

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| 0 680 | Continued From page 27<br><br>assisted living director (LALD)-A stated he did not have any written agreements with other locations if the facility needed to evacuate. LALD-A stated he would bring the residents to a local hotel but had not discussed with the hotel arrangements for housing assisted living residents. LALD-A confirmed the facility did not have all the components of Appendix Z developed and implemented. LALD-A stated RN-B would be the person most familiar with the emergency plan and that some of the components of Appendix Z had been formulated but was not written down anywhere. LALD-A stated they had discussed some parts of their emergency plan but had not thought to formulate it in a written policy or procedure that could be accessed by staff.<br><br>The licensee's 9.02 Disaster Planning and Emergency Preparedness policy, dated August 1, 2021, indicated the licensee would have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z.<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 720 SS=F | 144G.43 Subd. 2 Access to records<br><br>The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. | 0 720 | | |

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| 0 720 | Continued From page 28<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure that the appropriate records for four of four residents (R1, R2, R3, R4), and unlicensed personnel (ULP)- D were readily available for timely access to employees, vendors, and the commissioner authorized to access the records.<br><br>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).<br><br>The findings include:<br><br>During entrance conference on October 3, 2022, at approximately 11:35 a.m., licensed assisted living director (LALD)-A stated resident records and employee records were stored on site at the facility.<br><br>On October 3, 2022, at 11:45 a.m., the surveyor requested from LALD-A medical records for R1, R2, R3, and R4. ULP-D's employee record was also requested.<br><br>On October 3, 2022, at 12:00 p.m., medical records for R1, R2, R3, and R4 were requested again from assistant director (AD)-B. ULP-D's employee record was also requested again.<br><br>On October 3, 2022, at 1:00 p.m., AD-B stated she was not able to locate the requested records | 0 720 | | |

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| 0 720 | Continued From page 29<br>and was not sure where they records were. AD-B stated the records were normally stored on site.<br><br>On October 3, 2022, at 1:30 p.m., LALD-A entered the facility and was observed carrying several large, white binders containing medical records for R1, R2, R3, and R4. LALD-A also provided ULP-D's employee record at this time. LALD-A stated the nurse had brought the records home.<br><br>On October 3, 2022, at 2:45 p.m., registered nurse (RN)-C stated resident records are always stored on site except for today. RN-A stated she had some follow up work to do with the records and had taken them off site to get some work done.<br><br>On October 3, 2022, at 2:50 p.m., LALD-A stated it was his expectation that records be stored onsite and he was not aware the records were taken off site.<br><br>The licensee's policy, 2.35 Resident Record - Access & Storage, dated August 1, 2021, indicated resident records will be kept confidential and locked in a secured in an area where only authorized staff of Bright Side Healthcare LLC will have access. Records will be readily available to employees and contractors authorized to access the records at Bright Side Healthcare LLC. The resident record will be kept at 6907 Perry Avenue North, Brooklyn Center, MN, 55429. Resident records will be maintained in a manner that allows for timely access, printing, or transmission of the records. Resident records will be made available to MDH as requested.<br><br>No further information was provided. | 0 720 | | |

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| 0 720 | Continued From page 30<br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 720 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain facility fire extinguishers. This had the potential to affect all current residents, staff and visitors.<br><br>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).<br><br>The findings include:<br><br>During the facility tour on October 03, 2022, between 12:50 p.m. and 2:00 p.m., survey staff | 0 790 | | |

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| | 37859 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 790 | Continued From page 31<br>toured the facility with the assistant director (AD)-B, and observed the fire extinguishers were stamped on the bottom "2021". The surveyor was unable to verify when the extinguishers were purchased and or serviced.<br><br>AD-B verbally confirmed survey staff observations during the facility tour.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 790 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all | 0 800 | | |

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| 0 800 | Continued From page 32<br>of the residents). The findings include:<br><br>On October 03, 2022, between 12:50 p.m. and 2:00 p.m., survey staff toured the assisted director (AD)-B. During the facility tour, survey staff observed the following:<br><br>1. There is a leak under the bathroom sink in room 1.<br><br>AD-B verbally confirmed survey staff observations during the facility tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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. | 0 810 | | |

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| 0 810 | Continued From page 33<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>On October 03, 2022 between 12:50 p.m. and 2:00 p.m., the assistant director (AD)-B failed to provide documents for review.<br><br>Documents were reviewed by survey staff on | 0 810 | | |

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| 0 810 | Continued From page 34<br>October 03, 2022 between 12:50 p.m. and 2:00 p.m.,<br><br>1. The licensee failed to provide employee training logs for fire safety and evacuation.<br>2. The licensee failed to provide the required employee training frequency.<br>3. The licensee failed to provide documentation of resident evacuation training.<br>4. The licensee failed to provide a proper plan showing the procedures for the resident movement, evacuation, or relocation during a fire or other similar emergency.<br><br>The AD-B verbally confirmed survey staff observations during the facility tour.<br><br>No additional information was provided<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 970 SS=F | 144.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living | 0 970 | | |

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| 0 970 | Continued From page 35<br>contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents.<br><br>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).<br><br>The findings include:<br><br>On October 3, 2022, at 2:00 p.m., licensed assisted living director (LALD)-A provided the licensee's Assisted Living Contract and indicated the contract is signed by all residents who received services under the licensee's assisted living facility with dementia care license.<br><br>The licensee's cotnract included the following liability language:<br>-Page 15 "Insurance" of the contract indicated the resident agrees that the community is not responsible for any loss or damage to resident's personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond the community's control. Residents are strongly encouraged to obtain renter's insurance. Resident acknowledges that the community will not and does not maintain insurance coverage that will reimburse resident or their guests for damage to personal property, accident, or injury.<br>-Page 15. "Indemnification" of the contract indicated the resident would indemnify and hold harmless the community, its employees and | 0 970 | | |

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| 0 970 | Continued From page 36<br><br>agents from and against any and all claims, actions, damages, and liabilities and expenses in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the apartment or any other part of the community's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents.<br>-Page 15 "Liability" of the contract indicated the community is not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment or on the community premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident or resident's guests. The community may be liable to resident for it's own negligent acts or those of its employees or agents. Unless caused by one of the mentioned excepted reasons, resident agrees to hold the community harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on the community premise.<br><br>On October 3, 2022, at 2:20 p.m., LALD-A confirmed the contract contained language which waived the licensee's liability for the residents' health and safety and personal property. LALD-A stated he was not aware that could not be in the contract.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |

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| 01470 | Continued From page 37 | 01470 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any | 01470 | | |

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| 01470 | Continued From page 38<br>training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received orientation to assisted living facility licensing to include all the required topics with records reviewed.<br><br>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).<br><br>The findings include: | 01470 | | |

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| 01470 | Continued From page 39<br><br>ULP-D was hired September 19, 2022, to provide direct care and services to the licensee's residents.<br><br>ULP-D's employee record lacked the following required orientation content:<br>- an overview of the 144G statutes;<br>- policies and procedures related to the provision of assisted living services by the individual staff person;<br>- the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>- a review of the types of assisted living services the employee will be providing and the facility's category of licensure;<br>- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br><br>On October 3, 2022, at 11:35 a.m., ULP-D was observed filling out training competency forms covering various topics including an overview of assisted living statutes, the bill of rights, and consumer advocacy services. ULP-D did not reply when asked what training she was | 01470 | | |

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| 01470 | Continued From page 40<br>completing or if she had recieved training from the RN.<br><br>When the surveyor was reviewing ULP-D's employee record, the forms had been placed in the record. The forms were signed by the ULP but had not been signed by the RN.<br><br>On October 3, 2022, at 2:50 p.m., RN-C stated ULP-D completed video training and some training with her. RN-C stated she was not sure why the ULP was filling out orientation forms.<br><br>The licensee's Orientation of Staff and Supervisors and Content policy, dated August 1, 2021, indicated all licensee's employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01470 | | |
| 01610 SS=D | 144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic | 01610 | | |

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| 01610 | Continued From page 41 | 01610 | | |

distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed a physical and cognitive assessment of a prospective resident on or before move-in for one of one residents (R1) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's signed resident agreement indicated the resident moved into the facility and began receiving services on December 1, 2021.

R1's diagnoses included anxiety, type two diabetes, and chronic pain.

R1's service plan, dated December 21, 2021, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, medication administration, three times per day wellness check,

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| 01610 | Continued From page 42<br>housekeeping, and laundry.<br><br>R1's record lacked an admission assessment. R1's record contained a comprehensive assessment dated December 21, 2021, 20 days after moving in to the facility.<br><br>On October 3, 2022, at 3:10 p.m., RN-C confirmed some assessments had been missed for R1.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01610 | | |
| 01620 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 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.<br>(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.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under | 01620 | | |

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| 01620 | Continued From page 43<br>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.<br><br>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 comprehensive re-assessments timely for two of two residents (R1, R3). In addition, the licensee failed to ensure the uniform assessment tool included all required content for one of one residents re-assessed (R1).<br><br>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).<br><br>The findings include:<br><br>R1<br>R1's signed resident agreement indicated the resident moved into the facility and began receiving services on December 1, 2021.<br><br>R1's diagnoses included anxiety, type two diabetes, and chronic pain.<br><br>R1's service plan, dated December 21, 2021, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, medication administration, three times per day wellness check, housekeeping, and laundry. | 01620 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01620 | Continued From page 44<br><br>R1's record lacked an admission assessment and a 14 day re-assessment. R1's record contained a comprehensive assessment dated December 21, 2021, 20 days after moving in to the facility.<br><br>R1's record contained a one page Sample Monitoring and Reassessment form completed on March 1, 2022, March 9, 2022, and April 15, 2022. The re-assessment did not contain all the required content of the Uniform Assessment tool.<br><br>R1's record lacked any assessments after April 15, 2022.<br><br>R3<br>R3's signed resident agreement indicated the resident moved into the facility and began receiving services on August 2, 2022.<br><br>R3's diagnoses included attention deficit disorder, bipolar disorder, and delusion disorder.<br><br>R3's service plan, dated August 2, 2022, indicated the resident received the following services: assistance with toileting, bathing, medication administration, assistance with eating, three times per day wellness check, housekeeping, and laundry.<br><br>R3's record contained an admission assessment, dated August 2, 2022. R3's record lacked a 14 day re-assessment.<br><br>On October 3, 2022, at 3:10 p.m., RN-C confirmed some assessments had been missed for R1 and R3. RN-C stated she was not aware the Uniform Assessment Tool was to be used for all re-assessments and thought the one page form was sufficient for re-assessments. | 01620 | | |

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| 01620 | Continued From page 45<br><br>The licensee's 6.03 Uniform Assessment Tool policy, dated August 1, 2021, indicated the licensee would use a uniform assessment tool that addresses all of the required elements.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01620 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced | 01640 | | |

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| 01640 | Continued From page 46<br>by:<br>Based on interview and record review, the licensee failed to ensure a service plan was completed within 14 days including a signature or other authentication by the resident/guardian to document agreement on the services provided for one of two residents (R1) with records reviewed.<br><br>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).<br><br>The findings include:<br><br>R1's signed resident agreement indicated the resident moved into the facility and began recieving services on December 1, 2021.<br><br>R1's diagnoses included anxiety, type two diabetes, and chronic pain.<br><br>R1's service plan, dated December 21, 2021, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, medication administration, three times per day wellness check, housekeeping, and laundry.<br><br>R1's service plan was signed 20 days after the resident began receiving services.<br><br>On October 3, 2022, at 3:10 p.m., registered nurse (RN)-C confirmed some of R1's admission documents had not been completed timely. | 01640 | | |

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| 01640 | Continued From page 47<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01640 | | |
| 01750 SS=F | 144G.71 Subd. 7 Delegation of medication administration<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<br><br>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) prepared in writing specific instructions for each resident and documented those instructions for two of two residents (R1, R3) when the RN did not provide staff with a medication administration record (MAR).<br><br>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 | 01750 | | |

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| 01750 | Continued From page 48<br>of the residents).<br><br>The findings include:<br><br>R1<br>R1's record lacked specific written instructions regarding the administration of medications and did not contain a MAR for October 2022.<br><br>R1's diagnoses included anxiety, type two diabetes, and chronic pain.<br><br>R1's service plan, dated December 21, 2021, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, medication administration, three times per day wellness check, housekeeping, and laundry.<br><br>R1's record lacked signed prescriber orders.<br><br>R3<br>R3's record lacked specific written instructions regarding the administration of medications and did not contain a MAR for October 2022.<br><br>R3's diagnoses included attention deficit disorder, bipolar disorder, and delusion disorder.<br><br>R3's service plan, dated August 2, 2022, indicated the resident received the following services: assistance with toileting, bathing, medication administration, assistance with eating, three times per day wellness check, housekeeping, and laundry.<br><br>R3's record lacked signed prescriber orders. | 01750 | | |

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| 01750 | Continued From page 49<br><br>On October 3, 2022, at 1:30 p.m., assistant director (AD)-B stated she had worked as a ULP over the weekend of October 1 and October 2, 2022. AD-B stated she noticed there was no MAR and had called the RN for direction. The RN did not bring in MARs for staff but advised the ULP it was ok to give the medications that were set up in the mediboxes. AD-B stated she wrote down on a piece of paper what medications she gave.<br><br>On October 3, 2022, at 1:45 p.m., licensed assisted living director (LALD)-A confirmed he was not aware there were no MARs printed or provided to ULP for October. LALD-A stated he did not know how staff were passing medications without a MAR.<br><br>On October 3, 2022, at 2:15 p.m., R1 stated she wasn't sure if she had received all her medications the last few days or if she had gotten the appropriate medications.<br><br>On October 3, 2022, at 2:45 p.m., RN-C confirmed she had not yet put out MARs for all four residents. RN-C stated the printer had quit working and she had brought the MARs home to work on them. RN-C stated she liked to go through the MAR and ensure it matched what the pharmacy had sent before she puts the MAR out for staff. RN-C was not able to confirm if staff had been giving medications as prescribed for October 1, October 2, and October 3. RN-C was not sure how staff were documenting what they were giving and had not provided any guidance to staff on how to document or verify the medications they were giving were correct. RN-C confirmed it was not appropriate nursing practice to have ULP administer medications without a MAR. | 01750 | | |

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| 01750 | Continued From page 50<br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01750 | | |
| 01760 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 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide unlicensed personnel (ULP) the medication administration records (MAR) and maintain documentation of medication administered for two of two residents (R1, R3) reviewed.<br><br>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 | 01760 | | |

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| 01760 | Continued From page 51<br>of the residents).<br><br>The findings include:<br><br>The licensee failed to provide the MAR for unlicensed staff administering medications to R1 and records of R1's administered medications.<br><br>R1<br>R1 admitted to the facility December 1, 2021.<br><br>R1's diagnoses included anxiety, type two diabetes, and chronic pain.<br><br>R1's service plan, dated December 21, 2021, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, medication administration, three times per day wellness check, housekeeping, and laundry.<br><br>R1's record did not contain a MAR for October 2022.<br><br>R3<br>R3 admitted to the facility August 2, 2022.<br><br>R3's diagnoses included attention deficit disorder, bipolar disorder, and delusion disorder.<br><br>R3's service plan, dated August 2, 2022, indicated the resident received the following services: assistance with toileting, bathing, medication administration, assistance with eating, three times per day wellness check, housekeeping, and laundry.<br><br>On October 3, 2022, at 1:30 p.m., assistant director (AD)-B stated she had worked as a ULP over the weekend of October 1 and October 2, | 01760 | | |

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| 01760 | Continued From page 52<br><br>2022. AD-B stated she noticed there was no MAR and had called the RN for direction. The RN did not bring in MARs for staff but advised the ULP it was ok to give the medications that were set up in the mediboxes. AD-B stated she wrote down on a piece of paper what medications she gave.<br><br>On October 3, 2022, at 1:45 p.m., licensed assisted living director (LALD)-A confirmed he was not aware there were no MARs printed or provided to ULP for October. LALD-A stated he did not know how staff were passing medications without a MAR.<br><br>On October 3, 2022, at 2:15 p.m., R1 stated she wasn't sure if she had received all her medications the last few days or if she had gotten the appropriate medications.<br><br>On October 3, 2022, at 2:45 p.m., RN-C confirmed she had not yet put out MARs for all four residents. RN-C stated the printer had quit working and she had brought the MARs home to work on them. RN-C stated she liked to go through the MAR and ensure it matched what the pharmacy had sent before she puts the MAR out for staff. RN-C was not able to confirm if staff had been giving medications as prescribed for October 1, October 2, and October 3. RN-C was not sure how staff were documenting what they were giving and had not provided any guidance to staff on how to document or verify the medications they were giving were correct. RN-C confirmed it was not appropriate nursing practice to have ULP administer medications without a MAR.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) | 01760 | | |

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| 01760 | Continued From page 53<br>Days | 01760 | | |
| 01820 SS=F | 144G.71 Subd. 13 Prescriptions<br><br>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider managed to two of two residents (R1, R3) with records reviewed.<br><br>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).<br><br>The findings include:<br><br>On October 3, 2022, at 11:25 a.m., the surveyor observed a locked medication room with unlicensed personnel (ULP)-D. ULP-D showed the surveyor bins labeled for each of the four residents in the facility and confirmed the residents receivedd medication administration services. | 01820 | | |

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| 01820 | Continued From page 54<br>R1<br>R1 admitted to the facility December 1, 2021.<br><br>R1's diagnoses included anxiety, type two diabetes, and chronic pain.<br><br>R1's service plan, dated December 21, 2021, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, medication administration, three times per day wellness check, housekeeping, and laundry.<br><br>R1's record did not contain a MAR for October 2022.<br><br>R1's record did not contain signed prescriber orders for medications the provider managed.<br><br>R3<br>R3 admitted to the facility August 2, 2022.<br><br>R3's diagnoses included attention deficit disorder, bipolar disorder, and delusion disorder.<br><br>R3's service plan, dated August 2, 2022, indicated the resident received the following services: assistance with toileting, bathing, medication administration, assistance with eating, three times per day wellness check, housekeeping, and laundry.<br><br>R3's record did not contain a MAR for October 2022.<br><br>R3's record did not contain signed prescriber orders for medications the provider managed.<br><br>On October 3, 2022, at 3:00 p.m., registered nurse (RN)-C confirmed she did not have signed | 01820 | | |

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| 01820 | Continued From page 55<br>prescriber orders for any of the licensee's residents. RN-C stated she was not aware signed prescriber orders were required and she had been using orders she would get from the pharmacy.<br><br>The licensee's Medication & Treatment policy dated August 1, 2021, indicated all orders for medications would be dated and signed by the prescriber and must be current and consistent with the nursing assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01820 | | |
| 02290 SS=F | 144G.91 Subd. 2 Legislative intent<br><br>The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee limited the rights of two of two residents (R1, R3) reviewed when the licensee required the resident or their representative to sign a Behavior Contract as a condition of admission.<br><br>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 | 02290 | | |

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| 02290 | Continued From page 56 | 02290 | | |

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:

On October 3, 2022, the surveyor reviewed resident records for R1 and R3.

Both records contained a document titled "Behavior Contract." The contract was to be signed by the resident as a condition of admission. The contract contained the following language:

"Any rude, threatening, demeaning comments or behaviors will be immediately called out by the Bright Side Health Care will be terminated temporarily (sic) if Bright Side Health Care Team member feels uncomfortable. Care will resume when respectful behavior is observed, and respectful communication is used. Bright Side Health Care will ask case manager, primary providers, and family to intervene if negative behaviors continue after requests have been made to stop. Bright Side Health Care reserves the right to immediately terminate lease and services if behaviors persist.

Any physically threatening behavior demonstrated by the client or family will result in the immediate termination of lease and services by the Bright Side Health Care Team member will immediately contact 911 (sic).

Families are welcomed and recognized as an important part of your well-being. However, Bright Side Health Care will not tolerate profanity,

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 02290 | Continued From page 57<br>disruptive behavior, or any behavior that interferes with the care of any client.<br><br>Bright Side Health Care has a Zero Tolerance for any alcohol or drug use on the agency property, abusive actions or language, or any other behavior that creates risk or threat to other clients, families, or care team. Anyone, including families violating our zero-tolerance policy will be asked to leave the premise immediately. Bright Side Health Care staff will call 911 if the violator does not leave peacefully."<br><br>On October 4, 2022, at 2:30 p.m., LALD-A confirmed residents were required to sign the Behavior Contract prior to admission.<br><br>The licensee's policy, Protecting Resident Rights, dated August 1, 2021, indicated it was the policy of Bright Side Healthcare LLC to protect the rights of our residents. Bright Side Healthcare LLC will not request or require that any resident waive any of the rights provided at any time for any reason, including as a condition of admission.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02290 | | |
| 02400 SS=F | 144G.91 Subd. 12 Visitors and social participation<br><br>(a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain | 02400 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37859 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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|---|---|---|---|---|
| 02400 | Continued From page 58 | 02400 | | |

circumstances if necessary for the resident's health and safety and if documented in the resident's service plan.
(b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents.

This MN Requirement is not met as evidenced by:
Based on interview, the licensee failed to respect the resident's right to receive visits at any time. This had the potential to affect all four residents at the facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

Findings include:

On October 4, 2022, at R3 stated a few weeks ago, he had invited two friends come over later in the evening. R3 stated he was told by the unlicensed personnel on duty that she would call the police if he had visitors over. R3 stated the visitors came to the facility and were turned away and not allowed to see him. R3 stated this made him feel bad because the friends had driven a long distance to see him.

R3's service plan, dated August 2, 2022, did not

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|---|---|---|---|
| | 37859 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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|---|---|---|---|---|
| 02400 | Continued From page 59<br>indicate any restrictions to visitors that would be necessary for the resident's health and safety.<br><br>On October 4, 2022, at 3:10 p.m., licensed assisted living director (LALD)-A confirmed the facility enforced visiting hours for the residents. LALD-A stated a resident had tried to have visitors at 11 p.m. and they did not allow it because they needed to "have a way to keep structure in the house." LALD-A stated he was not aware facilities could not refuse to allow a resident to receive visitors at any time.<br><br>The licensee's policy, 2.05 Visitors and Social Participation Policy, dated August 1, 2021, indicated residents have the right to meet with or receive visitors at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the right of other residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02400 | | |
| 02430 SS=F | 144G.91 Subd. 15 Confidentiality of records<br><br>(a) Residents have the right to have personal, | 02430 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37859 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 02430 | Continued From page 60 | 02430 | | |

financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party.
(b) Residents have the right to access their own records.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure residents personal health and medical information was kept private. This has the potential to affect all four residents residing at the facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On October 4, 2022, at 12:05 p.m. assistant director (AD)-B stated the licensee communicated resident changes and updates with staff via a group WhatsApp chat. AD-B stated all employees are in the chat and if any health or medication changes occured with a resident, the information would be shared in the group chat. AD-B stated the resident's full names were not used. AD-B stated she was not sure if staff member's phones had passcodes on them

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37859 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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|---|---|---|---|---|
| 02430 | Continued From page 61<br>or if people besides the staff members would be able to access anything on their personal phones. AD-B confirmed staff not on duty would be able to review the group messages and there was no time limit on messages posted in the group chat. In addition, there were no systems in place to ensure the protected health information of residents was misused by staff. AD-B showed the surveyor the group chat on her cellphone. The group chat contained information on resident changes and medication changes.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02430 | | |
| 03090 SS=C | 144.6502, Subd. 8 Notice to Visitors<br><br>Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."<br><br>(b) The facility is responsible for installing and maintaining the signage required in this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all four current residents, staff, and visitors. | 03090 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37859 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIGHT SIDE HEALTHCARE LLC | 6907 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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|---|---|---|---|---|
| 03090 | Continued From page 62<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On October 3, 2022, at 11:15 a.m., the surveyor entered the facility. No signage was posted in the entrance or common areas disclosing electronic monitoring activity.<br><br>On October 3, 2022, at 12:30 p.m., assistant director (AD)-B confirmed a notice on electronic monitoring was not posted. AD-B thought it had been posted at one point but was unable to locate the posting.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 03090 | | |

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

Type: Full
Date: *10/04/22*
Time: 10:36:16
Report: 1024221198

# Food and Beverage Establishment Inspection Report



**Location:**
Bright Side Healthcare LLC
6907 Perry Ave N
Brooklyn Center, MN55429
Hennepin County, 27

**Establishment Info:**
ID #: 0040830
Risk:
Announced Inspection: Yes

**License Categories:**

Expires on: 12/31/22

**Operator:**

Phone #:
ID #:

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

The following orders were issued during this inspection.

**7-200 Toxic Supplies and Applications**

7-207.11B ** Priority 1 **

MN Rule 4626.1660B Label and locate personal medications in areas that do not contaminate food, equipment, linens, and single-service and single-use articles.

OBSERVED INSULATION MEDICATION IN REFRIGERATOR. ADVISED TO MAINTAIN MEDICATIONS IN LOCK BOX OR SEPARATE COOLER.

*Comply By: 10/04/22*

**3-500C Microbial Control: date marking**

3-501.17A ** Priority 2 **

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

NO DATE MARK OBSERVED ON OPENED BAG OF SOFT CHEESE SUCH AS MOZZARELLA CHEESE. ADVISED TO COMPLY PER ABOVE RULE.

*Comply By: 10/04/22*

**4-200 Equipment Design and Construction**

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

OBSERVED CROCK POT AND AIR FRYER THAT ARE NOT ANSI-APPROVED. PER STAFF, CROCK POT BELONGS TO RESIDENT. STATES AIR FRYER WILL BE REMOVED FROM PREMISES IMMEDIATELY.

Type: Full
Date: *10/04/22*
Time: 10:36:16
Report: 1024221198
Bright Side Healthcare LLC

# Food and Beverage Establishment Inspection Report

*Comply By: 10/04/22*

**Surface and Equipment Sanitizers**

Chlorine: = 100 PPM at  Degrees Fahrenheit
Location: SANI SPRAY
Violation Issued: No

Utensil Surface Temp: =  at 180+ Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding/CHEESE
Temperature: 42 Degrees Fahrenheit  - Location: KENMORE REFRIGERATOR - MAIN KITCHEN
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 42 Degrees Fahrenheit  - Location: KENMORE REFRIGERATOR - MAIN KITCHEN
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit  - Location: FRIGIDAIRE REFRIGERATOR - BACK AREA
Violation Issued: No

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

DISCUSSED THE FOLLOWING ON SITE WITH FOOD MANAGER, DAMAWA JALLAH:

- ALL ORDERS ON REPORT.
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- REPORTABLE DISEASES.
- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM. WILL SEND APPLICATION AND FACT SHEET TO FOOD MANAGER.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY. ESTABLISHMENT CALIBRATES MONTHLY. DISCUSSED CALIBRATING WHEN NEW THERMOMETER IS PURCHASED, AFTER THERMOMETER IS DROPPED, AND AFTER BATTERIES ARE CHANGED.
- DATE MARKING AND DISCARD DATE.
- PROPER STACKING ORDER TO AVOID CROSS CONTAMINATION.
- PROPER TEMPERATURES FOR HOT AND COLD HOLDING, REHEATING.
- PROPER SANITIZING LEVELS AND TEST KITS AND STRIPS ON SITE.

- 360 TRAINING LEARN 2 SERVE CERTIFICATE.
DAMAWA LOHOE JALLAH.
ISSUED: 6/3/22.
L2SC-3-021560.
NO EXP DATE.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME-DAY SERVICE. OBSERVED INTACT LAMINATE FLOORING, INTACT AND SMOOTH CEILINGS AND WALLS. ALL WERE FOUND TO BE INTACT AND IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH TIME THESE ITEMS ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, ITEMS WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHING MACHINE IS RESIDENTIAL HOWEVER HAS SANTIZING CYCLE OPTION. ESTABLISHMENT HAS KITCHEN LOG AND TEMP TEST STRIP SHOWS THAT DISHWASHING MACHINE REACHED 180 dF ON 10/1. DISHWASHING MACHINE IS TESTED WEEKLY.

NURSING EVALUATOR WAS NOT ON SITE AT TIME OF INSPECTION.

**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 1024221198 of 10/04/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____

DAMAWA LOHOE JALLAH
FOOD MANAGER

Signed:_____

Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us