Electronically Delivered

November 18, 2024

Licensee
Fardi Homes LLC
4915 Fillmore Street Northeast
Columbia Heights, MN 55421

RE: Project Number(s) SL39984015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on October 16, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39984	A. BUILDING: _____ B. WING _____	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARDI HOMES LLC	4915 FILLMORE STREET NE COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39984015-0 On October 14, 2024, through October 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one resident; one receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 650		

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0 650	Continued From page 2 The findings include: ULP-C was hired May 21, 2024, to provide direct care for the licensee's residents. On October 15, 2024, at 7:25 a.m., the surveyor observed ULP-C monitor and redirect R1's behaviors as R1 was talking loudly in a heightened voice and pacing in the garage. ULP-C's employee record did not include evidence ULP-C received the following required training and/or competencies: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth and gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -standby assistance techniques and how to perform them; and -range of motion and positioning. On October 15, 2024, at 9:00 a.m., ULP-C stated the registered nurse (RN) completed competencies as part of the training before working with the residents. On March 16, 2024, at 9:00 a.m., during telephone interview, RN-B stated ULP-C received training through Educare (computer training program) and an RN completed competencies. Additionally, she stated ULP-C's competencies were completed, she just could not find them all. The licensee's Staff Competency policy dated July 5, 2024, indicated all residents will receive quality service delivered by staff who are	0 650		

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0 650	Continued From page 3 educated and competent in the delivery of assisted living services. [Facility] is committed to meeting or exceeding current practice standards. The licensee's Staff Orientation and Education policy dated July 5, 2024, indicated upon hire and before providing services to residents, all employees attend a general orientation conducted by [facility name]. Those providing direct services will complete a competency evaluation as part of orientation process. The orientation checklist will be used to document and verify the completion of orientation for each employee. Upon completion of the orientation, the signed/dated orientation check list will be retained in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.	0 660		

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0 660	Continued From page 4 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including documentation of a completed health history and symptom screening for one of two employees, (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility's TB risk assessment was completed July 17, 2024, and was determined to be a low risk level. ULP-C was hired May 21, 2024, to provide direct care services to the facility's residents. ULP-C's employee record included documentation of a negative QuantiFERON (TB blood test) on August 15, 2024, however, the employee record lacked a TB a history and symptom screen.	0 660		

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0 660	Continued From page 5 On October 14, 2024, at 2:54 p.m., licensed assisted living director (LALD)-A stated she was unable to find ULP-C's TB history and symptom screen in his employee file but thought for sure it was done and could have been misplaced. The licensee's TB Screening and Prevention policy dated July 5, 2024, indicated baseline testing is completed on hire for all direct care providers. Baseline screening includes an assessment for TB history and current TB symptoms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680		

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0 680	Continued From page 6 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect all residents, staff, and visitors of 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: The licensee's Emergency Preparedness Manual dated May 10, 2024, lacked the following content: -the provision of subsistence needs for staff and resident to include food, medical supplies, pharmacy supplies, and emergency lighting. In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local	0 680		

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0 680	Continued From page 7 EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families. On October 16, 2024, at 9:35 a.m., via phone interview, licensed assisted living director (LALD)-A stated the licensee was missing the provision of subsistence, food, medical supplies, pharmacy supplies, emergency lighting and a communication plan in the licensee's EPP. The licensee's Emergency Preparedness policy dated July 5, 2024, indicated the [facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is	0 680		

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0 680	Continued From page 8 incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 780		

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0 780	Continued From page 9 failed to provide smoke alarms inside all sleeping rooms in the facility. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-D, on October 15, 2024, from 11:50 a.m. to 1:55 p.m., it was observed that smoke alarms were not provided in bedroom 2. These deficient conditions were visually verified by CNS-D accompanying on the tour. On October 15, at 1:30 p.m., LALD-A stated they had installed new smoke alarms, but resident in that room continues to remove that smoke alarm. LALD-A stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 10 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and	0 810		

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0 810	Continued From page 11 drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour with licensed assisted living director (LALD)-A, on October 15, 2024, from 11:50 a.m. to 1:55 p.m., surveyor observed the posted evacuation plans lacked identification of resident rooms. On October 15, 2024, LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", dated 2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety	0 810		

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0 810	Continued From page 12 systems such as fire doors and smoke compartments. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On October 15, 2024, at 11:30 a.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided records were for fire	0 810		

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	39984	A. BUILDING: _____ B. WING _____	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 13 safety training offered by third-party online software that could not be modified to include the facility-specific fire safety plans. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for employees on the fire safety and evacuation plan. On October 15, 2024, at 11:30 a.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drills", undated, indicated evacuation drills were conducted on June 14, 2024, July 11, 2024, September 19, 2024. No other documentation was provided. On October 15, 2024, at 11:30 a.m., LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440		

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01440	Continued From page 14 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel, (ULP)-C. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01440		

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01440	Continued From page 15 The findings include: ULP-C was hired May 21, 2024, to provide direct care for the licensee's residents. On October 15, 2024, at 7:25 a.m., the surveyor observed ULP-C monitor and redirect R1's behaviors as R1 was talking loudly in a heightened voice and pacing in the garage. ULP-C's employee record did not include documentation of a registered nurse (RN) supervising ULP-C performing a delegated task within 30 days of beginning work with the licensee. On October 16, 2024, at 9:00 a.m., during a phone interview, RN-B stated ULP-C's 30-day supervision was completed, but unable to find in ULP-C's employee file. The licensee's Supervision: Unlicensed Staff policy dated July 5, 2024, indicated direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility	01730		

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01730	Continued From page 16 must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730		

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01730	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a current individualized medication management record to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 14, 2024, at 11:30 a.m., during the entrance conference, registered nurse (RN)-B stated the licensee provided medication management services. R1's diagnoses included paranoid schizophrenia (mental health condition), depression and human immunodeficiency virus (a virus that attacks immune system). R1's Medication Management Plan dated May 17, 2024, indicated the resident received medication administration daily. R1's Home Health Aide Care Plan dated May 17, 2024, indicated R1 received medication administration and verbal reminder to take medications. R1's prescriber order dated July 16, 2024, indicated R1 was able to manage his own	01730		

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01730	Continued From page 18 medications for himself in the assisted living facility. R1's 90- day assessment dated July 29, 2024, indicated R1 wanted to manage his medications, which the provider had approved. R1's 90-day assessment dated September 9, 2024, indicated R1 was independent in medication administration, but needed reminders from staff. R1's medication management plan lacked updating for R1 to manage medications himself with verbal reminders to take medications. On October 16, 2024, at 9:57 a.m., via phone interview, RN-B stated the medication management plan was not updated for R1 to self-administer medications, but RN-B did change the task for ULP to give reminders to take his medications. Additionally, RN-B stated updating the medication plan must have been missed. The licensee's Medication Management Plan policy dated July 5, 2024, indicated the medication management plan will be evaluated/updated as needed in changes in medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy	01790		

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01790	Continued From page 19 is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the	01790		

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01790	Continued From page 20 medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP)-C) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away when the licensed nurse was not available. 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 14, 2024, at 11:30 a.m., during the entrance conference, registered nurse (RN)-B	01790		

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01790	Continued From page 21 stated the licensee provided medication management services. ULP-C was hired May 21, 2024, to provide direct care services to the licensee's residents, including medication administration. ULP-C's employee record lacked evidence to indicate ULP-C had been trained and demonstrated competency to provide medications to residents for unplanned times away from home. On October 15, 2024, at 9:00 a.m., ULP-C stated he thought he was trained in orientation for setting up medications for unplanned time away. On October 16, 2024, at 9:00 a.m., during a phone interview, RN-B stated the ULP should have been trained at orientation and would need to check with clinical nurse supervisor (CNS), if the competency was not in his employee record. The licensee's Medication Management Plan for Residents Away from Home policy dated July 5, 2024, indicated for unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the RN in a timely manner, the RN may delegate to an ULP to provide the medications based on the following: The RN has trained the ULP and determined the ULP competency to follow procedures for giving medications to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01790		

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

Type: Full
Date: *10/15/24*
Time: 09:50:00
Report: 1013241123

Food and Beverage Establishment Inspection Report

Location:
FARDI HOMES LLC
4915 FILLMORE STREET NE
Columbia Heights, MN55421
Anoka County, 02

Establishment Info:
ID #: 0043719
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

NO MN CFPM WAS AVAILABLE OR COULD BE VERIFIED. STAFF HAD A CURRENT FOOD MANAGERS COURSE CERTIFICATE. THE MN CFPM INFORMATION WAS PROVIDED.

Comply By: 12/06/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Freezer
Temperature: 12 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

Process/Item: Eggs
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cheese
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Type: Full
Date: *10/15/24*
Time: 09:50:00
Report: 1013241123
FARDI HOMES LLC

Food and Beverage Establishment Inspection Report

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator A. Boutwell.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has laminate cabinets, wood floor, painted walls, solid counter top, and a smooth painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, food storage, and food handling procedures.

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 1013241123 of 10/15/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Ruun Jama
Operator

Signed:_____
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us