Electronically Delivered

June 21, 2024

Licensee
Thomas Residence
1324 Thomas Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL36740015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 31, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH 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. MDH 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the 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 resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

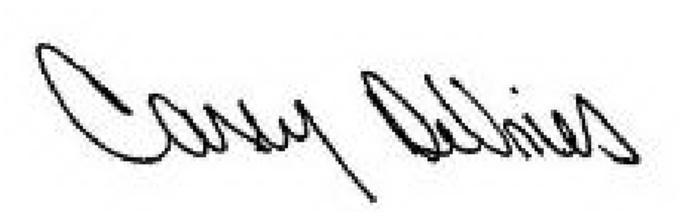
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36740	A. BUILDING: _____ B. WING _____	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS RESIDENCE	1324 THOMAS AVENUE NORTH MINNEAPOLIS, MN 55411

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0 000	Initial Comments ******ATTENTION****** 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: SL36740015-0 On May 28, 2024, to May 30, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents, both were receiving services under the 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. 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 28, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on May 29, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual	0 650		

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0 650	Continued From page 2 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 included documentation of completed training and competency for unlicensed personnel (ULP) providing cares and medications to residents for unplanned times away from home when the licensed nurse was not available for two of three employees (ULP-B and ULP-E). Further, the licensee failed to ensure employee records included an annual performance review for one of three employees (ULP-E). 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	0 650		

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0 650	Continued From page 3 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). The findings include: ULP-B ULP-B was hired on February 28, 2024, to provide direct care services to residents. The surveyor observed ULP-B providing cares for residents on May 28, 2024. ULP-B's employee record lacked documentation of completed training and competency for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a	0 650		

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0 650	Continued From page 4 licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -understanding appropriate boundaries between staff and residents and the resident's family; -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; In addition, ULP-B's employee record lacked documentation of training for administering medications to residents for unplanned time away. ULP-E ULP-E was hired on August 30, 2022, to provide direct care services to residents. ULP-E's employee record included one Seed Home Healthcare Performance Evaluation completed on September 29, 2022. ULP-E's record lacked an annual performance review due to be completed by September 29, 2023. ULP-E's employee record lacked documentation of training for administering medications to residents for unplanned time away. On May 29, 2024, at 12:05 p.m., ULP-B stated they worked for the licensee and had received training for unplanned times away and required	0 650		

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0 650	Continued From page 5 competencies. On May 29, 2024, at 12:47 p.m., licensed assisted living director (LALD)-D stated they did not have further documentation for the missing competency training topics. On May 29, 2024, at 3:11 p.m., clinical nurse supervisor (CNS)-A stated they did complete training and competencies for ULP-B. CNS-A stated they had an Educare competency list they used for ULP education and acknowledged they were not documenting each competency as having been completed when training ULPs. CNS-A stated they were aware of the required competency training topics. CNS-A stated they were completing unplanned times away training for all ULPs. CNS-A stated they thought unplanned times away training was documented in Educare. The licensee's Personnel Records policy dated August 1, 2021, indicated: "At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: · Evidence of current professional licensure, registration or certification · Results of background studies · Records of annual training and infection control training · Documentation of orientation · Documentation of supervision, as applicable · Performance reviews · Competency evaluations · Signed job description · Documentation of annual performance reviews identifying areas of improvement needed and training needs"	0 650		

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0 650	Continued From page 6 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure tuberculosis (TB) testing was completed within 90 days prior to the date of hire for two of three employees (unlicensed personnel (ULP)-B, ULP-E). Further, the licensee failed to ensure annual training was completed for one of three employees (ULP-E). 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	0 660		

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0 660	Continued From page 7 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on February 28, 2024, to provide direct care services to residents. The surveyor observed ULP-B providing cares for residents on May 28, 2024. ULP-B's employee record lacked evidence of a TB test completed by either a two-step Mantoux skin test or QuantiFERON blood test. ULP-E ULP-E was hired on August 30, 2022, to provide direct care services to residents. ULP-E's employee record included a Quest Diagnostics TB test result form, which indicated a negative result on May 13, 2022. The TB test result was completed 109 days prior to ULP-E's date of hire, or, 19 days past the 90-day requirement. ULP-E's employee record included an Educare (online training platform) transcript which indicated TB training was last completed on August 30, 2022, under the OSHA and Infection Control training module. ULP-E's record lacked further TB training required to be completed annually. On May 29, 2024, at 12:47 p.m., licensed assisted living director (LALD)-D stated the only documents they had for TB testing and training	0 660		

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0 660	Continued From page 8 were provided to the surveyor. LALD-D stated ULP-B had a TB test completed but was unable to locate the documentation. LALD-D stated they would review ULP-E's record for additional Educare transcripts as they thought their annual TB training had been completed. LALD-D stated they were aware of the TB testing and training requirements, and it was their job to make sure it had been completed. The CDC Tuberculosis Guidance website, last updated December 15, 2023, indicated all health personnel should receive TB education annually. The Minnesota Department of Health TB FAQ indicated all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. It further indicated TB testing should be dated within 90 days before hiring. The licensee's TB risk assessment completed on January 1, 2024, indicated the licensee was at a low risk level, and "All Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. TB education should include information on TB exposure (both occupational and nonoccupational) risk factors, the signs and symptoms of TB disease, and TB infection control policies and procedures." It further indicated, "Baseline TB screening of patients is required at time of admission for health care settings licensed as boarding care homes and nursing homes. Baseline TB screening includes: (1) two-step TST or single TB blood test, (2) TB symptom screen, and (3) assessment of the patient's risk factors for TB exposure and progression."	0 660		

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0 660	Continued From page 9 The licensee's Infection Control policy dated August 1, 2021, indicated, "The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control." The licensee's Personnel Records policy dated August 1, 2021, indicated, "Results of required health screening and medical examinations will be maintained in a separate, private file." 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 make emergency and disaster training annually	0 680		

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0 680	Continued From page 10 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 observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: On May 28, 2024, the licensee's Emergency Preparedness Plan, last reviewed on August 1, 2021, lacked the following: -Evidence of annual update including documentation of the date of review and any updates made to the plan based on the review; -Evidence the licensee developed strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); -Evidence of quarterly update for their missing resident plan quarterly;	0 680		

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0 680	Continued From page 11 -Evidence the licensee identified at risk population needs for transportation; -Evidence the licensee developed policies/procedures (P/P) to address: system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -Evidence the licensee developed and implemented EP P/P to address the following whether evacuated or shelter in place for staff/residents: Food, water, medical supplies, pharmaceutical supplies; -Evidence the licensee developed P/P for system to track the location of on-duty staff and sheltered residents; -Evidence the licensee developed P/P to address safe evacuation from the facility, including transportation; -Evidence the licensee developed P/P for shelter in place for residents, staff, and volunteers who remain in the facility; -Evidence the licensee developed P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -Evidence the licensee developed P/P to address: use of volunteers, including the process/role for integration; -Evidence the licensee developed P/P to address the role of the licensee under a waiver declared by the Secretary in accordance with section 1135 of the Act; -Names and contact information of residents' physicians; -Evidence the licensee developed a communication plan to include: primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; and -Evidence the licensee developed a	0 680		

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0 680	Continued From page 12 communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives. On May 28, 2024, at 12:45 p.m., licensed assisted living director (LALD)-D stated they had not reviewed their EPP annually or the missing resident policy quarterly. LALD-D stated they did not have a breakdown of shelter in place supply needs, but they did have a purchased survival supply backpack. The surveyor observed the supply backpack which indicated it was for four people for three days. The supply backpack included survival items with four liters of water and four food bars. The surveyor questioned LALD-D if they thought the supply backpack had enough food and water for three days and four people, they stated, "honestly, I don't know but it doesn't sound like it." LALD-D acknowledged the EPP lacked the above listed missing items. LALD-D stated this was their first time getting feedback on their EPP and would check available resources to address it. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "Seed Home Healthcare 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." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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	36740	A. BUILDING: _____ B. WING _____	05/31/2024

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0 800	Continued From page 13	0 800		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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 on May 28, 2024, at 10:45 a.m., with licensed assisted living director (LALD)-D, the surveyor made the following observations of facility hazards and disrepair: The cover was missing from the fan/ light exposing the light bulb and fan interior housing in	0 800		

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0 800	Continued From page 14 the main floor bathroom ceiling. Electrical fixtures are required to be maintained with all manufacture supplied covers in accordance with manufactures instructions. During a facility tour on May 28, 2024, at 10:50 a.m., LALD-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in 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	0 810		

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0 810	Continued From page 15 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a 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 May 30, 2024, at 9:00 a.m., licensed assisted living director (LALD)-D, 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 FSEP dated December 8, 2023, failed to include the following:	0 810		

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0 810	Continued From page 16 The number of resident sleeping rooms were not indicated on the FSEP floor plan and the resident sleeping room in the lowest level marked as room 4 on the door was not drawn on the floor plan. The FSEP floor plan is required to include resident room numbers identifying each resident room and corresponding to the number identified on the door of the room. The FSEP did not identify specific fire protection actions for residents evident by not providing written procedures for resident to take during a fire or similar emergency in the plan and available for review at all times. 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 failed to include resident evacuation status/ unique needs for evacuation of each individual resident in writing in the plan and available for reference at all times. During an interview on May 30, 2024, at 9:20 a.m., LALD-D stated the resident specific procedures to be taken during a fire or similar emergency and unique needs of each resident for evacuation were not provided in writing and available in the FSEP. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation training was provided as required for employees.	0 810		

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0 810	Continued From page 17 During an interview on May 30, 2024, at 9:30 a.m., LALD-D, stated documentation was not available indicating training was provided to employees upon hire and twice per year thereafter. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation drills were completed every other month but did not provide documentation drills were completed twice per year per shift. The documentation provided did not indicate a time or shift for any of the drills documented. During an interview on May 30, 2024, at 9:40 a.m., LALD-D, stated the drill documentation provided did not include drill time or shift number for the documented drills but will include the time and shift number in drill documentation moving forward. 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 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems	01440		

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01440	Continued From page 18 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 a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-B and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on February 28, 2024, to provide direct care services to residents.	01440		

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01440	Continued From page 19 The surveyor observed ULP-B providing cares for residents on May 28, 2024. ULP-B's employee record included a Seed Home Healthcare Performance Evaluation form completed on March 29, 2024, completed by house manager/ULP (HM/ULP)-C. The form did not address direct supervision of staff performing delegated tasks and was not completed by an RN. ULP-E ULP-E was hired on August 30, 2022, to provide direct care services to residents. ULP-E's employee record included a Seed Home Healthcare Performance Evaluation form completed on September 29, 2022, completed by clinical nurse supervisor (CNS)-A. The form did not address direct supervision of staff performing delegated tasks. ULP-B and ULP-E's employee records lacked evidence a RN supervision was conducted within 30 days of providing services. On May 29, 2024, at 3:11 p.m., clinical nurse supervisor (CNS)-A stated they were completing a RN 30-day supervision and described the Seed Home Healthcare Performance Evaluation form. The surveyor explained the form for ULP-B and ULP-E lacked documentation of delegated tasks and competencies supervised by the RN. CNS-A stated they were not aware the RN 30-day supervision should include competencies and delegated tasks. The licensee's Delegation of Assisted Living Tasks policy dated August 1, 2021, indicated:	01440		

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01440	Continued From page 20 "6. The clinician may delegate procedures according to the following a. The clinician instructed the home health aide in the proper methods to perform the procedure with respect to each resident. b. The clinician provided the home health aide with written instructions specific to the resident. c. The home health aide demonstrated to the clinician competence in the procedure. d. The procedure is documented in the resident's clinical record. e. The home health aide's competence is documented in his/her personnel file. 7. The clinicians will have access to the staff members' personnel files or other reports to determine level of competence prior to delegation of any task so that up-to-date information about current available staff and their competency is available to have sufficient information to determine the appropriateness of delegating tasks to meet the resident's needs and preferences. 8. If a home health aide has not regularly performed a delegated task for a period of 24 consecutive months, the home health aide will demonstrate competency in the task to the RN or other licensed health professional prior to performing the task. 9. All home health aides providing delegated nursing services to residents of Seed Home Healthcare are oriented by the clinician prior to initiation of the service. This orientation may be verbal, written, electronic or on-site according to the clinician's judgment. 10. A clinician (RN for consultation to staff performing delegated nursing tasks and/or another appropriately licensed health professional) will be readily available to staff performing delegated services via phone or by	01440		

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01440	Continued From page 21 other appropriate means during times when the staff is performing services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services	01500		

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01500	Continued From page 22 and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for two of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-E). 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	01500		

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01500	Continued From page 23 resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-A CNS-A was hired on January 10, 2022, to provide oversite of ULPs, and direct care services and assessments for residents. CNS-A's employee record included an Educare (online training platform) transcript which included CNS-A's completed annual trainings done between January 22 and 28, 2024. It lacked annual training for the following topics: -reporting maltreatment of vulnerable adults or minors; and -review of provider's policies and procedures. ULP-E ULP-E was hired on August 30, 2022, to provide direct care services to residents. ULP-E's employee record included an Educare transcript which included ULP-E's completed annual trainings done October 14, 2023. It lacked annual training for the following topics: -infection control techniques; -effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and -review of provider's policies and procedures. CNS-A and ULP-E's employee records lacked	01500		

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01500	Continued From page 24 further evidence of completed annual training. On May 28, 2024, at 1:45 p.m., licensed assisted living director (LALD)-D stated all annual training was completed on Educare. On May 29, 2024, at 12:47 p.m., LALD-D stated they thought all of CNS-A's annual training was on their Educare transcript completed in January 2024. The surveyor explained the Educare transcript indicated CNS-A's most recent training was completed in January 2023. LALD-D stated they mistakenly thought it was completed in October 2023. LALD-D stated CNS-A must not have completed the required annual training. LALD-D stated they thought they provided ULP-E's annual training and would check for additional Educare documentation. On May 29, 2024, at 1:01 p.m., LALD-D emailed an additional Educare transcript for ULP-E which was a duplicate of the annual trainings already provided. It included annual trainings completed on October 14, 2023. On May 29, 2024, at 3:11 p.m., CNS-A stated they completed their annual training in Educare. The surveyor explained the Educare transcript indicated their most recent training was completed in January 2023. CNS-A stated they would review their own records for additional annual training documentation. On May 30, 2024, at 10:07 a.m., LALD-D stated CNS-A provided them with an additional Educare transcript which they then emailed to the surveyor. The Educare transcript included additional annual training topics completed between January 22 and 28, 2024, but still lacked reporting maltreatment of vulnerable adults and	01500		

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01500	Continued From page 25 review of providers policies and procedures. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated: "12. All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 13. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights c. Review of the organization's policies and procedures related to provision of assisted living services and how to implement them d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations per the CDC***** ii. Hand washing techniques iii. Need for/use of personal protective equipment (PPE), including: 1. Gloves 2. Gowns 3. Masks iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases e. Effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or related disorders f. The principles of person-centered planning and service"	01500		

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01500	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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

Type: Full
Date: *05/28/24*
Time: 12:45:00
Report: 1013241044

Food and Beverage Establishment Inspection Report

Location:
Thomas Residence
1324 Thomas Avenue North
Minneapolis, MN55411
Hennepin County, 27

Establishment Info:
ID #: 0038801
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123454655
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

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

NO MN CFPM WAS POSTED OR AVAILABLE. THE MN CFPM INFORMATION WAS VERIFIED ON THE MDH WEBSITE. COMPLY WITH RULE.

Comply By: 06/04/24

Surface and Equipment Sanitizers

Hot Water: = at 159 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Raw shell eggs
Temperature: 39 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Process/Item: Deli meat
Temperature: 37 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Process/Item: Milk
Temperature: 38 Degrees Fahrenheit - Location: Basement refrigerator
Violation Issued: No

Type: Full
Date: *05/28/24*
Time: 12:45:00
Report: 1013241044
Thomas Residence

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 J. Keen.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, wood floor, painted walls, laminate 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, 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 1013241044 of 05/28/24.

Certified Food Protection Manager: Ahmed Bashir Mohamed

Certification Number: 113362 Expires: 10/07/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Abdulahi Mohamed
Operator

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