NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 2, 2024

Licensee
St. John Home Care LLC
10805 South Shore Drive
Medicine Lake, MN 55441

RE: Conditional License Number 415151
Health Facility Identification Number (HFID) 37126
Project Number(s) SL37126015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 29, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144A.

As a result, pursuant to Minn. Stat. § 144A.475, MDH is issuing a 90-day conditional license due to expire on **December 31, 2024**.

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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144A.474, Subd. 11(a), fines and enforcement actions may be imposed based on the level and scope of the violations and may be 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 § 144A.475 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144A.475.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $3,000.00. **MDH is not imposing these fines against your license at this time.**

0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

In accordance with Minn. Stat. § 144A.474 Subd. 11, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey at your agency**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144A.474, Subd. 8(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes Chapter 144A.**

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's client(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. § 144A.474, Subd. 12, 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 business days of the correction order receipt date.

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

CONDITIONAL LICENSE ISSUED:
MDH will issue St. John Home Care LLC a conditional comprehensive home care license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144A.474, Subd. 2(e). Based on the results of the follow-up survey, MDH will determine if St. John Home Care LLC is in substantial compliance.

The following conditions apply on the conditional comprehensive 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:** St. John Home Care LLC will not admit any new clients under its conditional home care license until MDH removes the "no new admissions" condition. St. John Home Care LLC must provide the Department:

    i. A list of the names and birthdates of any individuals St. John Home Care LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

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

c. **Consultant:** St. John Home Care LLC will contract with an RN to provide consultation concerning all clients to whom St. John Home Care LLC provides licensed comprehensive home care services under the conditional license. <u>The consultant must have access to all clients receiving services from St. John Home Care LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct client 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 St. John Home Care LLC and MDH must review the RN's credentials and approve the selection. St. John Home Care LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to St. John Home Care LLC in an effort to help St. John Home Care LLC align their practices with the requirements of Minn. Stat. §§ 144A.43 – 144A.484 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. St. John Home Care 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 substantial 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 St. John Home Care LLC and the RN consultant about a change. Each report will be

electronically submitted to Jessie Chenze, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at jessie.chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering home care services and the level of competency observed;
iii. Conversations with clients and family members about satisfaction with home care 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 home care services delivered;
vi. Overall impressions about the dignity with which the clients 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 St. John Home Care LLC to correct the violations cited during the survey as well as to determine the overall practice of St. John Home Care 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 provisional licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Health Facility Construction Permit:** St. John Home Care LLC, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, St. John Home Care LLC, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

g. **General Contractor:** St. John Home Care LLC must provide the following to Tim Hanna (Tim.Hanna@state.mn.us) via email within 21-days of the date of this notice:
   i. Name
   ii. License Number
   iii. Contact Information

h. **Egress Window Requirements:** St. John Home Care LLC will replace at least one

window in occupied resident sleeping rooms #3 meeting the minimum size requirements.

i. Must have a minimum openable width of no less than 20 inches
ii. Must have a minimum openable height of no less than 20 inches
iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
iv. Must have a windowsill height of no more than 48 inches from the floor
v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

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

j. **Corrective Action Plan:** St. John Home Care 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 substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if St. John Home Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines St. John Home Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from St. John Home Care LLC's comprehensive home care license, and St. John Home Care LLC will correct violations identified during the survey to come into substantial compliance. If MDH determines St. John Home Care LLC is not in substantial compliance, MDH may take additional enforcement action against St. John Home Care LLC, including placement of additional conditions, issuing an extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144A.475 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144A.475, Subd. 3c(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.

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

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

If you have any questions, please contact Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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 ******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: SL337126015-0 On August 26, 2024, through August 29, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; both receiving services under the provider's Assisted Living license. An immediate correction order was identified on August 29, 2024, issued for SL37126015-0, tag identification 0820.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 250	Continued From page 1 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: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (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; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (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; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: 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. This had the potential to 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 26, 2024, at 12:07 p.m., clinical nurse supervisor	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 250	Continued From page 3 (CNS)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - 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. - 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. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 250	Continued From page 4 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 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. - 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. - 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. - I have examined this application and all	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 250	Continued From page 5 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 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. - 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. Page six was electronically signed by CNS-A on November 22, 2023. The licensee had an assisted living license issued on January 1, 2024, with an expiration date of December 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial and ongoing resident evaluations and assessments of resident needs,	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 250	Continued From page 6 including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (6) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (7) medication and treatment management; (8) delegation of tasks by registered nurses or licensed health professionals; (9) supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0250, 0430, 0470, 0480, 0485, 0550, 0580, 0630, 0650, 0660, 0680, 0770, 0800, 0810, 0820, 0910, 0930, 1290, 1370, 1380, 1440, 1500, 1560, 1620, 1640, 1650, 1700, 1820, 1880, 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 430	Continued From page 7 prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents. 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 the potential to affect a large portion or all the residents). The findings include: During the entrance conference on August 26,	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 430	Continued From page 8 2024, at 12:07 p.m., clinical nurse supervisor (CNS)-A stated the current census for this licensee was two residents, however, neither resident was present at that time because she stated one resident was working, and the other resident was with his family. CNS-A stated there was one staff scheduled for each shift at this facility and described one unlicensed personnel (ULP) from 7:00 a.m. to 3:30 p.m., one ULP from 3:00 p.m. to 11:30 p.m., and she worked every day, Monday through Sunday, at this facility, from 11:00 p.m. to 7:30 a.m. CNS-A stated she also worked Monday through Sunday, 16 hours per day, sharing her time between all six of the facilities she owned. R1 and R2's records included Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), last updated November 29, 2022, signed by R1 on August 8, 2023, and signed by R2 with no date, indicated on page 1, under general information, an incorrect physical address of the facility, and the incorrect address on R2's UDALSA was crossed off in blue pen and another address was handwritten, but was still not the correct physical address of this facility. Also included on page 2, under general information, ULP were in the building and available to respond to resident requests 24/7 (24 hours per day/7 days per week), with two ULP typically scheduled on the day shift, two ULP typically scheduled on the evening shift, and two ULP typically scheduled on the night shift. On August 28, 2024, at 9:55 a.m., CNS-A stated she didn't realize the physical address on R1 and R2's UDALSA was incorrect, and stated she must have "grabbed the wrong one," when each resident was admitted. CNS-A had no explanation for the UDALSA including two staff for each shift	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 430	Continued From page 9 and again stated they only scheduled one staff for each shift. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy, dated October 1, 2021, indicated the licensee would keep the UDALSA current at all times and would disclose the amenities permitted under the facility's license, identifying all services and amenities the facility offers to provide and does not provide. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake;	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 470	Continued From page 10 (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan for determining the staffing level, that included an evaluation conducted at least twice a year of the appropriateness of staffing levels in the facility. In addition, the licensee failed to ensure the daily staffing schedule was posted in a central location in the facility, potentially affecting the licensee's current residents, staff, and any 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: The licensee held an assisted living facility license. The facility was licensed for a capacity of four residents, and during the survey had a census of two residents. During the initial facility tour with clinical nurse	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 470	Continued From page 11 supervisor (CNS)-A on August 26, 2024, at 1:37 p.m., the surveyor observed the entrance of the facility and common areas. The licensee lacked a daily staffing schedule developed by CNS-A, that was posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building, as required. The surveyor requested to review the facility's staffing plan to evaluate the appropriateness of the staffing levels in the facility. On August 26, 2024, at 1:40 p.m., CNS-A stated the daily staffing plan should have been posted and stated she must have taken it down and forgot to put it back up. CNS-A searched through a pile of papers on the dining room table, and provided an August 2024 schedule to the surveyor. The schedule indicated one staff, unlicensed personnel (ULP)-B, was scheduled every day of the month from 7:00 a.m. to 3:30 p.m., one staff, ULP-C, was scheduled every day of the month from 3:00 p.m. to 11:30 p.m., and one staff, CNS-A, was scheduled every day of the month from 11:00 p.m. to 7:30 a.m. CNS-A also provided a Staffing Plan, undated, that indicated the licensee would assure qualified employees would be scheduled to meet operational requirements and the needs of the residents. The plan indicated, "[Licensee] will have two unlicensed personnel present during the day shift from 7am to 3:30pm [sic]. One staff will remain on the premises at all times, while one staff will transport residents to and from the locations they want to go. [Licensee] will have two unlicensed personnel present during the evening shift from 3pm to 11:30pm [sic]. One staff will always remain on the premises, while one staff will transport residents to and from the locations they want to go. [Licensee] will have 1[one] unlicensed	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 470	Continued From page 12 personnel present during the overnight shift from 11pm to 7:30am [sic], who will always remain on the premises." The staffing plan lacked evidence of any staffing metrics used to determine appropriate staffing levels, did not describe the current staffing schedule, and lacked evidence that the staffing plan had been reviewed twice per year. On August 26, 2024, at 1:45 p.m., CNS-A stated she had been working on the staffing plan since learning she needed to do so during a survey at another facility that she owned, and stated the plan didn't match the staffing schedule at this facility. The licensee's Staffing & Scheduling policy, effective October 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct care staff to meet the residents' needs 24 hours a day, 7 days a week. The policy directed the daily work schedule must be posted at the beginning of each work shift in a central location accessible to staff, residents, volunteers, and the public. The policy did not indicate the staffing plan must be reviewed at least twice a year, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 480	Continued From page 13 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 27, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 485	Continued From page 14 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared a week in advance and made available to the residents. This had the potential to affect all residents. 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). The findings include: During the entrance conference on August 26, 2024, at 1:02 p.m., clinical nurse supervisor (CNS)-A stated the licensee's two residents determined what they wanted to eat, and the staff would buy the groceries.	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 485	Continued From page 15 During the initial tour on August 26, 2024, at 1:37 p.m., the surveyor observed a piece of paper on the kitchen counter, titled Weekly Menu Planner, dated August 5, 2024, to August 11, 2024, which included handwritten items for breakfast, lunch, dinner and snacks for each day that week. When asked why the menu wasn't for the current week, CNS-A stated the residents "don't follow the menu anyway." CNS-A stated there wasn't a menu for this week, and there was no menu prepared a week in advance, as required. During an interview on August 27, 2024, at 10:30 a.m., R1 stated the facility provided "shelter and food," for her. When asked about meals, R1 stated she didn't eat breakfast because she would get up and leave for work and didn't have time to make breakfast, and she came home for lunch most days, and would warm up "noodles." For supper, R1 stated sometimes when unlicensed personnel (ULP)-B was working, he would make supper, but she didn't know ahead of time what the meal was going to be. When asked if menus were provided, R1 stated, "No." On August 27, 2024, at 10:40 a.m., the surveyor observed while R1 placed a plastic container with noodles, into the microwave, and took them into her room to eat them. The licensee's Food Service & Menu Planning policy, effective October 1, 2021, indicated menus would be prepared at least a week in advance and made available to all residents, and the licensee would encourage residents' involvement in menu planning. No further information provided.	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 485	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect all current 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 550	Continued From page 17 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: The licensee failed to post information including the e-mail contact information for the individuals who were responsible for handling resident grievances. During the facility tour on August 26, 2024, at 1:37 p.m., the surveyor observed the dining area within the facility with clinical nurse supervisor (CNS)-A, and noted the posted grievance procedure posted near the entrance door. The licensee's Complaint/Grievance Posting, effective October 1, 2022, listed the name and phone number of the individual to contact to file a complaint; however, the document lacked the email contact information, as required. On August 26, 2024, at 1:40 p.m., CNS-A stated she didn't realize the contact information should include the email address for the individual listed to contact with a grievance. The licensee's Complaint/Grievance Posting, effective October 1, 2021, indicated the licensee would post, in a conspicuous place, information about the complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 550	Continued From page 18 (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 580	Continued From page 19 During the entrance conference on August 26, 2024, at 12:01 p.m., clinical nurse supervisor (CNS)-A stated the last quality management meeting was June 3, 2024, and stated she met with staff monthly. A request was made to review documentation of the licensee's quality management activities. CNS-A indicated she was unable to provide any documentation of ongoing quality management activities. The licensee's Quality Management Project policy, effective October 1, 2021, indicated the licensee would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each 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.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 630	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (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: R1's diagnoses included anxiety disorder, major depressive disorder, post traumatic stress disorder, and psychotic disorder. R1's Service Plan, signed August 8, 2023, indicated the licensee provided the following services to R1: assistance with dressing two times daily, assistance with grooming daily, assistance with bathing daily, verbal and visual medication reminders two times daily, medication administration two times daily, personal laundry three times per week, manage anxiety three times daily, and manage verbal aggression three times daily. On August 27, 2024, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated R1 became angry and verbally aggressive and stated R1 often needed interventions when she was paranoid and asking questions.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 630	Continued From page 21 R1's IAPP dated August 8, 2023, and reviewed August 21, 2023, identified R1's only vulnerability was visual difficulties and indicated R1 wore glasses. R1's IAPP failed to include: - the persons'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. On August 27, 2024, at 11:35 a.m., CNS-A stated R1's IAPP should have listed her vulnerabilities and the specific measures to minimize the risk of abuse. CNS-A stated R1's vulnerabilities had the potential to affect other residents and staff. The licensee's Individual Abuse Protection Plans policy, effective October 1, 2021, indicated all residents in an assisted living were considered vulnerable adults, and the licensee would develop and implement an IAPP for each vulnerable adult that would include: - individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults; - the resident's risk of abusing other vulnerable adults; - statements of the specific measures to minimize the risk of abuse to that person and other vulnerable adults; and - measures to minimize the risk of self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 650	Continued From page 22	0 650		
0 650 SS=E	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 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 interview and record review, the licensee failed to ensure employee records contained the required content for two of three employees (clinical nurse supervisor (CNS)-A, 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	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 650	Continued From page 23 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 started employment on July 18, 2021. CNS-A's record included a job description, dated August 13, 2022, with position title "Unlicensed Personnel," not for her current position as CNS. CNS-A's record lacked evidence of the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. ULP-C ULP-C had a start date of February 9, 2024. ULP-D's employee record lacked the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On August 27, 2024, at 10:30 a.m., CNS-A stated the above contents were missing from the employees' records. The licensee's Employee Records policy, effective October 1, 2021, indicated employee records for each person would include: -evidence of current professional licensure, registration or certificate, if required; -records of all training and in-service education required and/or provided including record of competency testing as required; -current signed job description, which includes	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 650	Continued From page 24 qualifications, responsibilities, and identification of supervisors, if any; -documentation of annual performance reviews that identify areas of improvement needed and training needs; -for individuals providing Assisted Living services, verification that required health screenings for tuberculosis have taken place and the dates of those screenings; -documentation of a completed background study; -evidence that a reference check has been completed; and -verification of completed orientation and annual training and competency testing as required. No further information was 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	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 660	Continued From page 25 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). This included documentation of a completed health history and symptom screening for one of three employees (unlicensed personnel (ULP)-C) and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for three of three employees (clinical nurse supervisor (CNS)-A, ULP-B, ULP-C). This had the potential to 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, 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: During the entrance conference on August 26, 2024, at 12:07 p.m., a request was made to review the facility TB risk assessment. The TB risk assessment provided was dated July 1, 2024, and indicated the licensee's TB risk level was "low." CNS-A CNS-A had a hire date of July 18, 2021, to	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 660	Continued From page 26 provide services and supervision under the licensee's Assisted Living license to the licensee's residents. CNS-A's employee record included a Serial TB Screening Tool for Health Care Workers (HCWs), dated July 30, 2023; however, lacked evidence of completion of a two-step TST or other evidence of TB screening such as a blood test. ULP-B ULP-B had a hire date of July 31, 2021, to provide services under the licensee's Assisted Living license to the licensee's residents. ULP-B's employee record included a Serial TB Screening Tool for Healthcare Workers (HCWs), dated July 1, 2024, and documentation of a TST, given April 11, 2017, or more than four years prior to hire. The record lacked evidence of the required screenings completed upon hire, as required. ULP-C ULP-C had a hire date of February 9, 2024, to provide services under the licensee's Assisted Living license to the licensee's residents. ULP-C's employee record lacked evidence of a TB history and symptom screening, and lacked evidence of completion of a two-step TST or other evidence of TB screening such as a blood test. On August 27, 2024, 10:24 a.m., CNS-A stated she was aware of the missing TB results due to being surveyed recently in another facility that she owned. The licensee's Tuberculosis Screening, effective	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 660	Continued From page 27 October 1, 2021, indicated staff whose essential job functions require work within the same air space of home care (sic) clients would be screened and tested for TB prior to the staff being exposed to clients. In addition, the policy directed new staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs, and would have a blood test or a two-step TST conducted with results documented. No staff would be permitted to begin work until the negative results of the first TST were read and documented or a negative blood test was received and documented. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 680 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 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 to view. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 680	Continued From page 29 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 August 28, 2024, at 10:52 a.m., the surveyor reviewed the licensee's Emergency Plan for [Licensee], undated, which lacked evidence of the following required information: - annual reviews/updates of plan; - all-hazards approach, including emerging infectious diseases (EID), as applicable; - documentation of the licensee's risk assessment (plan indicated the property was vulnerable to hurricanes and indicated they were more than 7 miles from an active railroad); - categorization of the various probable risks/hazards by likelihood of occurrence; - development of strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); - missing resident quarterly review; - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - annual review/update on policies and procedures; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for sheltering in place for residents, staff, and volunteers who remain in the facility (policy indicated "ALF [assisted living facility] will not be used as a shelter for evacuation."; - policies and procedures for medical documents;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 680	Continued From page 30 - development of policies and procedures for sewage and waste disposal; - policies and procedures for volunteers; - policies and procedures for transportation; - roles under a waiver declared by secretary; - names and contact information; - emergency officials contact information; - Primary/alternate means for communication; - methods for sharing information; -development of a communication plan to included: -federal, state, tribal, regional & local EP staff -state licensing and certification agency -MN Office of Ombudsman for LTC -other sources of assistance; -sharing information on occupancy/needs; and -emergency prep training and testing. On August 28, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-A stated she was aware the emergency preparedness plan "needed work," and laughed when discussing hazards listed included hurricanes and active railroad being more than 7 miles away from the facility, as trains were heard many times a day within a short distance from the facility. CNS-A stated they had a "bucket" with food supply that they would grab if needing to evacuate, however, stated she didn't know where the bucket was. CNS-A stated there was no facility vehicles available as noted in the plan, therefore, transportation would have to be provided by Uber or Lyft. CNS-A stated they did not review the missing resident quarterly, and had not conducted exercises to test the emergency twice per year, as required. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy, dated October 1, 2021, indicated the licensee's emergency preparedness plan would include all required	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 680	Continued From page 31 elements of Appendix Z and would be reviewed annually. The policy indicated the plan was based on the assisted living and community-based risk assessments, utilizing the all-hazards approach, including risk assessment and planning, policies and procedures, a communication plan, and staff training and exercises/drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to test the well water within the last year. This had the potential to directly affect all	0 770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 770	Continued From page 32 residents and staff. 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 August 29, 2024, at approximately 11:45 a.m., a well water test report docmentation was requested from clinical nurse supervisor (CNS)-A for review but not provided. The CNS-A confirmed the finding and stated that they did perform a water test when the home was purchased, but the report was not available or provided for review. On August 29, 2024, at approximately noon, the CNS-A acknowledged the finding during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 770		
0 800 SS=F	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.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 800	Continued From page 33 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the home with the clinical nurse supervisor (CNS)-A. During the home tour, survey staff observed the following: -The licensee lacked maintenance on the deck. Survey staff observed various parts of the wood deck were unstable and deteriorated with missing side railings and support posts. -The exterior window trimmings in the back of the house were deteriorating and needing repair and/or replacement. -No approved cigarette butt receptor for proper disposal in the home's designated smoking area in the back of the house. The CNS-A confirmed the finding and stated that they have ordered a	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 800	Continued From page 34 butt receptacle but have not assembled it yet. -A bee nest in the back exterior of the house inside a duct/vent. -Electrical outlets were missing cover plates in the kitchen, the living room, and the hallways throughout the house. -The door of resident room 1 failed to positively latch when closed. Survey staff explained to CNS-A that the door must latch positively for locking when closed for resident privacy and fire/smoke protection during a fire emergency. -The door to the garage did not self close for proper protection between the home and the garage. -The door between the main kitchen and hallway to the front door in the path of egress was not a standard-size door height for safe egress. Survey staff measured the door height at 69 inches and the doorknob at 25 inches above the finished floor and explained to CNS-A that door height dimension is too low and not permitted for installation in the path of egress. The CNS-A stated that the door was altered and installed to provide privacy between the kitchen and the front hallway. The CNS-A verified the finding at the time of discovery. -The ceiling heights in the lower-level hallways, three bedrooms, and bathrooms did not meet the state standard existing ceiling height of 78 inches and incorrect height locations of the doorknobs. Survey staff measured the ceiling heights at 69 inches to 72 inches and door knobs were installed at approximately 29-30 inches above the finished floor throughout the lower level. The CNS-A confirmed the ceiling heights were too low and stated that the lower level is not intended to be used for residents and they planned on remodeling the lower level sometime in the future. -Electrical outlets located within approximately two feet of plumbing fixtures in the lower-level	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 800	Continued From page 35 bathroom and in the kitchen were not protected with a ground-fault interrupter (GFI) for electrical safety. -Lack of a discharge pipe on the water heater temperature/pressure relief valve. The above deficient findings were verbally and/or visually verified by the CNS-A at the time of discovery. During an interview, survey staff explained the above deficient findings to the CNS-A and she understood and acknowledged the findings. No further information was provided. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 810	Continued From page 36 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, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and 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). The findings include:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 810	Continued From page 37 On August 29, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the home with the clinical nurse supervisor (CNS)-A. During the tour, survey staff observed the following: -Document review of the posted fire evacuation diagram (plan) and it did not include room numbers for each resident bedroom. Evacuation plans must include the location and resident sleeping room numbers. -Document review of the posted diagram indicated the diagram (plan) was not legible as it was drawn in pencil. The CNS-A verified the findings at the time of discovery. On August 29, 2024, at approximately noon, document and record review and interview with the CNS-A, on the home's fire safety and evacuation plan (undated, Disaster Plan for Fire), and related training policies, procedures, and records indicated the following: -Document review indicated the licensee's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. -Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the initial hire	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 810	Continued From page 38 training. No records were available or provided for review. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year. No records were available or provided for review. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month. No records were available or provided for review. The above deficient findings were verified by the CNS-A during the interview. On August 29, 2024, at approximately 12:30 p.m., survey staff explained the above deficient findings to the CNS-A. The CNS-A understood and acknowledged they lacked the above provisions during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 39 existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide the minimum state standard-sized egress windows for occupied resident sleeping room 3. This has the potential to directly affect the health, safety, and well-being of the resident in sleeping room 3. 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 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 August 29, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the home with the clinical nurse supervisor (CNS)-A. During the home tour, at approximately 10:30 a.m., survey staff measured the two double-hung windows inside the main-level resident sleeping room 3, and the window openings did not have windows that met the minimum openable state	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 40 standard-sized window requirement for safe egress. The sleeping room was occupied by a resident. The dimensions of the clear opening of double-hung windows in room 3 both measured at a width of 23 inches and a height of 21 inches with a total openable area of 483 square inches and did not meet the state standard-sized window for safe egress in a sleeping room with the required minimum width and height of no less than 20 inches of clear opening and also a minimum total open area of 648 square inches for safe egress. The above deficient finding was verbally and visually verified with the CNS-A at the time of discovery. The CNS-A stated that she recently measured the egress window and thought it needed to meet the minimum width and height of no less than 20 inches. Survey staff explained to CNS-A that the total openable clear area for egress windows must also meet the minimum of 648 square inches. Survey staff further explained that only one of the two windows in room 3 must meet the minimum egress window clear opening requirements. On August 29, 2024, at 11:30 a.m., survey staff explained to CNS-A that an immediate correction order was issued for the deficient finding in occupied resident sleeping room 3. Survey staff further explained that a plan of correction for the immediate order must be developed and submitted for approval to lift the immediacy. The CNS-A understood and acknowledged the finding. TIME PERIOD FOR CORRECTION: Immediate No further information was provided.	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 910	Continued From page 41	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). 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). The findings include: The licensee lacked a written contract with the following required content: -the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility; and	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 910	Continued From page 42 -the contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of the facility and contracted service provider when applicable. R1 R1's start of services was August 8, 2023. R1's Service Plan Agreement Information Sheet, identified as the contract, signed by R1 on August 8, 2023, lacked the HFID number of the facility, and incorrectly indicated the license capacity was "6." R2 R2's start of services was July 30, 2024. R2's Service Plan Agreement Information Sheet, signed by R2 on December 18, 2022, when he was admitted to another facility owned by the same licensee, lacked the HFID, incorrectly indicated the license capacity was "6," and had an incorrect physical address of the facility. On August 28, 2024, at 9:40 a.m., clinical nurse supervisor (CNS)-A stated she wasn't aware that the contract should include the HFID number, stated R2's contract was from the facility that he lived in prior to moving here and incorrectly listed the previous address, and stated the contract incorrectly indicated the license capacity was six because it wasn't changed when the licensee lowered the capacity to four residents. The licensee's Signing an Assisted Living Contract policy, effective October 1, 2021, did not address the required contents of the contract. No further information was provided.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 910	Continued From page 43 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2). 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	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 930	Continued From page 44 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 the potential to affect a large portion or all the residents). The findings include: R1 R1's Service Plan, signed August 8, 2023, indicated R1 received services including assistance with dressing two times daily, assistance with daily grooming and bathing, medication reminders two times daily, medication administration two times daily, personal laundry three times per week, and anxiety and verbal aggression three times daily. R1's Service Plan Agreement Information Sheet, identified as the contract, signed August 8, 2023, lacked the following content: -the right under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer; and -contact information for the Office of Health Facility Complaints. R2 R2's Service Plan, signed December 18, 2022, indicated R2 received verbal medication reminders, congregate meal preparation three times daily plus snacks, personal laundry one time per day, housekeeping one time daily, shopping one time per week, individual staff ratio 1:1 one time daily, anxiety management one time daily, repetitive behavior management one time	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
0 930	Continued From page 45 daily, agitation management one time daily, verbal aggression management one time daily, and property destruction management one time daily. R2's Service Plan Agreement Information Sheet, identified as the contract, signed December 18, 2022, lacked the following content: -the right under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer; and -contact information for the Office of Health Facility Complaints. On August 28, 2024, at 9:40 a.m., clinical nursing supervisor (CNS)-A stated the contract lacked the required content as noted above, and stated the contract needed to be changed because it was the same contract they used when they had a comprehensive home care license, and wasn't aware of the changes. The licensee's Signing an Assisted Living Contract policy, effective October 1, 2021, did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01290	Continued From page 46 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of three 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: ULP-C began employment on February 9, 2024, to provide direct care for the licensee's residents. ULP-C's employee record contained a background study dated February 13, 2024,	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01290	Continued From page 47 submitted through a separate location operated by the licensee's owner; however, ULP-C's employee record lacked evidence the licensee affiliated a background study for their assisted living license. On August 27, 2024, at 10:28 a.m., clinical nurse supervisor (CNS)-A provided the NETStudy 2.0 Roster Affiliation, which lacked ULP-C's name. On August 27, at 10:30 a.m., CNS-A stated ULP-C worked at other facilities that the licensee owned and stated ULP-C's background study from February 13, 2024, for the separate location was the only clearance the licensee obtained. The licensee's Background Studies policy, effective October 1, 2021, indicated no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study had been received. The policy lacked direction that the background study must be affiliated with the licensee, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01370	Continued From page 48 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) 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; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-C) to include all required content. This had the potential to affect all of the	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01370	Continued From page 49 licensee's 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, 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 August 26, 2024, at 1:40 p.m., clinical nurse supervisor (CNS)-A provided an August 2024 schedule to the surveyor. The schedule indicated one staff, ULP-C, was scheduled every day of the month, from 3:00 p.m. to 11:30 p.m. The surveyor did not observe ULP-C during the survey, because CNS-A stated ULP-C wasn't needed at the facility while CNS-A was there with the surveyor. ULP-C ULP-C was hired on February 9, 2024, to provide direct care services to residents of the facility. ULP-C's employee record lacked documentation of training and competency evaluations for the following: - appropriate and safe techniques in personal hygiene and grooming, including: (i) bathing; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, and food safety; and - preparation of modified diets as ordered by a licensed health professional.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01370	Continued From page 50 On August 27, 2024, at 11:09 a.m., CNS-A stated she didn't know why the training record wasn't complete, and stated the training depended upon what the ULP would be doing. CNS-A stated R1's service plan indicated assistance with bathing and the licensee provided meals, so ULP-C should have received the training. The licensee's Competency Training Evaluations policy, effective October 1, 2021, indicated prior to the registered nurse delegating services, they must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, the policy directed only ULP who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. Training and competency evaluations for all ULP will include: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them;	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01370	Continued From page 51 - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a 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; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation;	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01380	Continued From page 52 (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required, prior to providing direct care for one of two unlicensed personnel (ULP-C). This had potential to affect all of the licensee's 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). The findings include: On August 26, 2024, at 1:40 p.m., clinical nurse supervisor (CNS)-A provided an August 2024 schedule to the surveyor. The schedule indicated one staff, ULP-C, was scheduled every day of the month, from 3:00 p.m. to 11:30 p.m. The surveyor did not observe ULP-C during the survey, because CNS-A stated ULP-C wasn't needed at the facility while CNS-A was there with the surveyor. ULP-C ULP-C was hired on February 9, 2024, to provide direct care services to residents of the facility. ULP-C's employee record lacked documentation of training and competency evaluations for the	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01380	Continued From page 53 following: - observing, reporting, and documenting resident status; - safe transfer techniques and ambulation; and - range of motioning and positioning. On August 27, 2024, at 11:09 a.m., CNS-A stated she didn't know why the training record wasn't complete, and stated the training depended upon what the ULP would be doing. CNS-A stated, "We don't do transfers." The licensee's Competency Training Evaluations policy, effective October 1, 2021, indicated prior to the registered nurse delegating services, they must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, the policy directed only ULP who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. Training and competency evaluations for all ULP must include: - observing, reporting, and documenting 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; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required.	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01380	Continued From page 54 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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 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 interview and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for two of two unlicensed personnel	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01440	Continued From page 55 (ULP)-B, 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 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 had a hire date of July 31, 2021. ULP-B's record lacked evidence an RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks. ULP-C ULP-C had a hire date of February 9, 2024. ULP-C's record lacked evidence an RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks. On August 27, 2024, at 11:11 a.m., clinical nurse supervisor (CNS)-A stated she was unable to provide documentation of supervision within 30 days of performing delegated tasks for ULP-B and ULP-C, as required. The licensee's Supervision of Staff - Delegated Services policy, effective October 1, 2021, included, "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 licensee and first	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01440	Continued From page 56 performs the delegated tasks for residents, and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01500	Continued From page 57 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 annual training included all required topics for each 12 months of employment for one of two employees (clinical nurse supervisor (CNS)-A). 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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01500	Continued From page 58 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: CNS-A began employment with the licensee on July 18, 2021, to provide supervision and direct care services to the residents. CNS-A's employee training records lacked evidence of completing annual training as required, to include the following: - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 27, 2024, at 10:20 a.m., CNS-A stated she could not explain why her record did not have evidence of this training. The licensee's Annual Required Staff Training policy, effective October 1, 2021, indicated all staff that perform direct care services would complete at least eight (8) hours of annual training for each 12 months of employment, which must include review of the assisted living bill of rights and team member responsibilities related to ensuring the exercise and protection of those rights, and principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01500	Continued From page 59 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all residents. 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	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01560	Continued From page 60 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: When interviewed on August 26, 2024, at 1:50 p.m., clinical nurse supervisor (CNS)-A stated she did not have a description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered, in written or electronic form to consumers, and indicated she was not aware of this requirement. The licensee's Dementia Training policy, effective October 1, 2021, indicated the licensee would provide a written or electronic description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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. (d) For residents only receiving assisted living	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01620	Continued From page 61 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. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all areas of the uniform assessment tool as required per Minnesota Administrative Rule 4659.0150 were addressed for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: During the entrance conference on August 26, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated she completed initial	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01620	Continued From page 62 assessments before or on the day the resident moved in, 14 days, every 90 days, and when there was a change in condition. R1 R1 was admitted to the licensee and began receiving assisted living services on August 8, 2023. R1's diagnoses included anxiety disorder, major depressive disorder, post traumatic stress disorder, and psychotic disorder. R1's Service Plan, signed August 8, 2023, indicated the licensee provided the following services to R1: assistance with dressing two times daily, assistance with grooming daily, assistance with bathing daily, verbal and visual medication reminders two times daily, medication administration two times daily, personal laundry three times per week, manage anxiety three times daily, and manage verbal aggression three times daily. R1's Uniform Assessment Tool form, dated November 4, 2023, and indicated was reviewed on February 4, 2024, May 4, 2024, and July 30, 2024, identified as 90 day assessments. The February 4, 2024, review was late by two days. In addition, the following areas on the Uniform Assessment form dated, July 30, 2024, were left blank: -medication and environmental allergies; -emergency evacuation ability; -health care team summary of visits in past 12 months (primary care provider name/clinic was listed and first name of psychiatry was included), there was no information regarding last visit date/outcome, and although there were areas to address other providers such as dentist,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01620	Continued From page 63 optometrist, psychiatry, etc., they were left blank; -food dislikes, other preferences; -social history/needs; -use a psychotropic/antipsychotic medication use; -behavioral symptoms/expression including verbal aggression and angry outbursts was not addressed; -skin assessment, including color, moisture level, integrity; -infectious conditions; and -review of medications was completely blank. R2 R2 was admitted to the licensee and began receiving assisted living services on July 30, 2024. R2's diagnoses included anxiety disorder and paranoid schizophrenia. R2's Service Plan, signed December 18, 2022, indicated R2 received verbal medication reminders, congregate meal preparation three times daily plus snacks, personal laundry one time per day, housekeeping one time daily, shopping one time per week, individual staff ratio 1:1 one time daily, anxiety management one time daily, repetitive behavior management one time daily, agitation management one time daily, verbal aggression management one time daily, and property destruction management one time daily. R2's Uniform Assessment Tool form, dated July 30, 2024, and indicated was reviewed on August 13, 2024, identified as 14 day assessment. The following areas on the Uniform Assessment form were left blank: -medication and environmental allergies; -emergency evacuation ability;	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01620	Continued From page 64 -health care team summary of visits in past 12 months (primary care provider name/clinic/phone number was listed), there was no information regarding last visit date/outcome, and although there were areas to address other providers such as dentist, optometrist, psychiatry, etc., they were left blank; -food likes, dislikes, other preferences; -verbal pain assessment indicated a reported score of 6 on the pain scale of 0-10, indicating moderate chronic back and shoulder pain; areas to address duration, pharmacological and nonpharmacological treatments and effectiveness were not addressed; -areas to address R2's psychological concerns, use a psychotropic/antipsychotic medication use; -mood related signs for depression were not addressed; -skin integrity; -infectious conditions; and -review of medications (side effects/adverse reactions, allergic/adverse reactions, contraindications, difficulties in taking, interventions to prevent diversion not addressed for all medications assessed). On August 28, 2024, at 10:15 a.m., CNS-A could not explain why R1's assessment lacked any mention of current symptoms of mental health conditions and behaviors that were listed on the service plan, or a review of R1's medications when the licensee was providing medication reminders twice daily, and stated sometimes staff needed to administer medications when R1 was having a bad day. CNS-A stated the comprehensive assessments should be more complete and stated documentation should indicate all areas were reassessed with each reassessment, rather than just signing a date.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01620	Continued From page 65 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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. (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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (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. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for one of two residents (R1). In addition, the licensee failed to ensure a current written service plan was finalized no later than 14	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01640	Continued From page 66 calendar days after the date that services were first provided, for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: REVISION OF THE SERVICE PLAN R1 R1's diagnoses included anxiety disorder, major depressive disorder, post traumatic stress disorder, and psychotic disorder. R1's Service Plan, signed August 8, 2023, indicated the licensee provided the following services to R1: assistance with dressing two times daily, assistance with grooming daily, assistance with bathing daily, verbal and visual medication reminders two times daily, medication administration two times daily, personal laundry three times per week, manage anxiety three times daily, and manage verbal aggression three times daily. During the entrance conference on August 26, 2024, at 12:07 p.m., clinical nurse supervisor (CNS)-A stated the licensee was licensed for four residents, and currently had two residents, although stated neither resident was home at this time. CNS-A stated R1 was working and would be gone most of the day, and R2 was with family, expected back to the facility later that afternoon.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01640	Continued From page 67 Neither resident returned while the surveyor was onsite that day. On August 27, 2024, at 9:30 a.m., R1 entered the facility and stated she was on a break from work. When interviewed at 10:30 a.m., R1 stated she was the only resident until recently when R2 moved in. R1 stated she wasn't at the facility much because she worked, and stated the licensee provided her with shelter and food. R1 stated she liked to "do her own thing," did her own laundry because she didn't want anyone touching her clothes, preferred to cook her own food, did her own cleaning, self administered her own medications after staff reminded her by telephone, and was independent with all activities of daily living. On August 27, 2024, at 11:30 a.m., CNS-A stated, when R1 was admitted, she required reminders for dressing, grooming, bathing, and required medication administration, but "doesn't anymore." CNS-A stated the service plan should have been revised when those services were no longer being provided. NO SERVICE PLAN R2 R2 was admitted to the licensee and began receiving assisted living services on July 30, 2024. R2's diagnoses included anxiety disorder and paranoid schizophrenia. R2's Service Plan, signed December 18, 2022, indicated R2 received verbal medication reminders, congregate meal preparation three times daily plus snacks, personal laundry one time per day, housekeeping one time daily,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01640	Continued From page 68 shopping one time per week, individual staff ratio 1:1 one time daily, anxiety management one time daily, repetitive behavior management one time daily, agitation management one time daily, verbal aggression management one time daily, and property destruction management one time daily. The licensee provided no other service plans for R2. On August 27, 2024, at 2:52 p.m., CNS-A stated the current service plan was executed when R2 was admitted to another facility owned by the license, and a new service plan was not developed when R2 moved to this facility. CNS-A stated this placement was "only temporary" while renovations were being completed at his previous facility and stated R2 "doesn't understand why he has to resign everything." The licensee's Service Plan policy, effective October 1, 2021, indicated all residents receiving assisted living services would have a service plan in place, based on the outcomes of the initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. Within 14 days after the date that services are first provided to a resident, the licensee would finalize a written service plan. The licensee's Service Plan Modifications policy, effective October 1, 2021, indicated when a resident received assisted living services and a change(s) to the service plan occurred, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01640	Continued From page 69 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 70 the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's service plan lacked the following: - a contingency plan that included: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2's Service Plan, signed December 18, 2022, indicated R2 received verbal medication reminders, congregate meal preparation three times daily plus snacks, personal laundry one time per day, housekeeping one time daily, shopping one time per week, individual staff ratio 1:1 one time daily, anxiety management one time daily, repetitive behavior management one time daily, agitation management one time daily, verbal aggression management one time daily, and property destruction management one time	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 71 daily. The service plan lacked the required content noted above. On August 27, 2024, at 2:52 p.m., clinical nurse supervisor (CNS)-A confirmed the service plan for R2 lacked the required content noted above. The licensee's Service Plan policy, effective October 1, 2021, indicated the service plan would include a description of the services that were to be provided based on the most recent assessment and resident preferences, the fees for services, the frequency of each service, who will be providing the service, the schedule and method of monitoring assessment of the resident, the schedule and method of monitoring staff providing services, and a contigency plan that included what actions would be taken if the scheduled services could not be provided. Also, the policy indicated the service plan would identify how the resident or the resident's responsible person could contact a representative of the licensee, the name and telephone number of the resident's contact person in case of an emergency including identification of and contact information for who has the authority to sign for the resident in an emergency, and the circumstances in which emergency medical services were not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01700	Continued From page 72 management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the 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), and was issued at a widespread scope (when problems are pervasive	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01700	Continued From page 73 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: During the entrance conference on August 26, 2024, at 12:07 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. R1's diagnoses included anxiety disorder, major depressive disorder, post traumatic stress disorder, and psychotic disorder. R1's Service Plan, signed August 8, 2023, indicated the licensee provided the following services to R1: assistance with dressing two times daily, assistance with grooming daily, assistance with bathing daily, verbal and visual medication reminders two times daily, medication administration two times daily, personal laundry three times per week, manage anxiety three times daily, and manage verbal aggression three times daily. R1's Uniform Assessment Tool form, dated November 4, 2023, and indicated was reviewed on February 4, 2024, May 4, 2024, and July 30, 2024, identified as 90 day assessments. The following area on the Uniform Assessment form dated, July 30, 2024: -review of medications was completely blank. R1's record lacked prescriber orders. R1's Medication Administration Record (MAR), dated August 1, 2024, to August 31, 2024, indicated R1's medications included an antipsychotic and two antidepressants.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01700	Continued From page 74 R1's record lacked evidence the RN had conducted a medication assessment to include: - identification and review of all medications the resident is known to be taking; - must be conducted face to face; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions, and actions to address these issues; and - identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. R1's Individualized Medication Management Plan, dated August 8, 2023, and reviewed July 30, 2024, indicated R1 was "Independent in medication administration," and "Resident setup medications independently." Also included, the plan indicated R1 was able to safely store all medications independently and was responsible for monitoring supplies and ordering refills on a timely basis. On August 28, 2024, at 10:49 a.m., R1 stated she self administered her medications with reminders from staff and showed the surveyor where she stored her medications in the kitchen cupboard. On August 28, 2022, at approximately 10:52 a.m., CNS-A stated R1 needed reminders to take her medications and at times, needed staff to administer her medications when she was having a bad day. CNS-A stated the assessments lacked	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01700	Continued From page 75 the above required content. The licensee's Medication Management - Assessment, Monitoring & Reassessment policy, effective October 1, 2021, indicated prior to providing medication management services, the registered nurse, licensed health professional, or authorized prescriber would conduct an assessment to determine what medication management services would be provided and how the services would be provided. The assessment must be conducted face to face with the resident, must include an identification and review of all medications the resident is known to be taking, must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. Also included, the assessment must identify interventions needed in management of medications to prevent diversion of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01820 SS=F	144G.71 Subd. 13 Prescriptions 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01820	Continued From page 76 recorded prescriptions were obtained 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 an 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: During the entrance conference on August 26, 2024, at 12:07 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. R1's diagnoses included anxiety disorder, major depressive disorder, post traumatic stress disorder, and psychotic disorder. R1's Service Plan, signed August 8, 2023, indicated the licensee provided the following services to R1: assistance with dressing two times daily, assistance with grooming daily, assistance with bathing daily, verbal and visual medication reminders two times daily, medication administration two times daily, personal laundry three times per week, manage anxiety three times daily, and manage verbal aggression three times daily. R1's Uniform Assessment Tool form, dated November 4, 2023, and indicated was reviewed on February 4, 2024, May 4, 2024, and July 30, 2024, identified as 90 day assessments. The	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
01820	Continued From page 77 following area on the Uniform Assessment form dated, July 30, 2024: -review of medications was completely blank. R1's Medication Administration Record (MAR), dated August 1, 2024, to August 31, 2024, indicated R1's medications included an antipsychotic and two antidepressants. R1's record lacked prescriber orders. On August 27, 2024, at 11:46 a.m., CNS-A stated she had no prescriber orders for R1. The licensee's Medication & Treatment Orders policy, effective October 1, 2021, directed the registered nurse was responsible for assuring current, authorized prescriber orders for medications administered by the staff were kept on file in the residents' record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescription medications were securely locked in a	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 78 substantially constructed compartment and permitted only authorized personnel to have access 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), 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: During the entrance conference on August 26, 2024, at 12:07 p.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's resident. R1's diagnoses included anxiety disorder, major depressive disorder, post traumatic stress disorder, and psychotic disorder. R1's Service Plan, signed August 8, 2023, indicated the licensee provided the following services to R1: assistance with dressing two times daily, assistance with grooming daily, assistance with bathing daily, verbal and visual medication reminders two times daily, medication administration two times daily, personal laundry three times per week, manage anxiety three times daily, and manage verbal aggression three times daily. R1's record lacked prescriber orders. R1's Medication Administration Record (MAR), dated August 1, 2024, to August 31, 2024, indicated R1's medications included an	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 79 antipsychotic and two antidepressants. R1's Individualized Medication Management Plan, dated August 8, 2023, and reviewed July 30, 2024, indicated R1 was "Independent in medication administration," and "Resident setup medications independently." Also included, the plan indicated R1 was able to safely store all medications independently and was responsible for monitoring supplies and ordering refills on a timely basis. On August 28, 2024, at 10:49 a.m., R1 stated she self administered her medications with reminders from staff and showed the surveyor where she stored her medications in a kitchen cupboard. The cupboard was not locked and accessible to another resident residing in the facility, staff, and visitors to the facility. On August 28, 2022, at approximately 10:52 a.m., CNS-A stated she provided medication management for R1 because R1 needed reminders to take her medications and at times, needed staff to administer her medications when she was having a bad day. CNS-A stated the medications were accessible to others in their current location and stated they would figure out a different plan for storing R1's medications. The licensee's Medication Storage policy, effective October 1, 2021, indicated when medications were managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer's directions, and only authorized staff would have access to stored medications. No further information was provided.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 80 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
03090 SS=C	144.6502, 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." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not 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). The findings include: Upon entrance on August 26, 2024, at 12:01 p.m., the surveyor observed outside the front entrance and just inside the front entrance of the	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
03090	Continued From page 81 assisted living facility. There was no required posting for notification of electronic monitoring devices. During a tour of the facility on August 26, 2024, at 1:37 p.m., clinical nurse supervisor (CNS)-A confirmed no posting was available at the main entrance related to the statutory language for electronic monitoring, and stated there was electronic monitoring devices in the facility but they were in the common areas, not in the residents' rooms, so she didn't think they needed to post a sign. The licensee's Electronic Monitoring policy, effective October 1, 2021, indicated signs were installed at each facility entrance accessible to visitors that stated, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *08/27/24*
Time: 12:00:00
Report: 1025241168

Food and Beverage Establishment Inspection Report

Location:
St John Home Care Llc
10805 South Shore Drive
Plymouth, MN55441
Hennepin County, 27

Establishment Info:
ID #: 0038806
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9523001067
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened 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. The date must not exceed the manufacturer's use-by-date.

Deli meat without a date mark when opened, labeled as "prepared July" or "Aug 11." Items reported to belong to a more independent resident and were discarded during inspection. Mark the date and discard resident TCS food as needed to comply abova

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

Provide a means of testing the interior contact temperature in the dishwasher

Comply By: 08/30/24

2-100 Supervision

2-102.12AMN

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

Employ a CFPM for the establishment (discussed CFPM certificate had expired). Please search "MDH CFPM" for information on requirements

Comply By: 08/27/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

Delime/remove mineral build-up from the heating element in the dishwasher

Comply By: 09/06/24

Food and Equipment Temperatures

Process/Item: Bacon
Temperature: 41 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

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

Home reported is serviced by a private well in the front of the home (approx between front door and street) intact but less than 1' tall and did not appear to have an exterior screened vent
Discussed testing – annual for coliform and nitrate (although additional testing may be required by licenser). Reported last test was 8 months prior. Post well testing results near the license or otherwise keep on-hand for request by the health authority.

Delimed and remove hard water build-up from the inside of the dishwasher, particularity the heating element in the bottom. Follow label directions and wear protective equipment if done by staff and not hired out to a 3rd party. Maintain the heating element free of mineral build-up to make sure the dishwasher can reach sanitizing temperatures.

Provide a cleanable container for silverware in the drawers

Discussed discarding resident food which has gone past (7) days (for opened TCS items in the refrigerator), or spoiled (for dry pantry items)

FACILITY
Appliances are residential, vinyl floor, painted walls

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher with a sanitize cycle
Facility does not have a 3 compartment sink
Facility does not have a dedicated food preparation sink

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

Type: Full
Date: *08/27/24*
Time: 12:00:00
Report: 1025241168
St John Home Care Llc

Food and Beverage Establishment Inspection Report

DISHWASHING – NSF 184
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)
Recommend having an alternative means of sanitizing available case of emergency or service interruption

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 1025241168 of 08/27/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025241168

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 08/27/24
Time In 12:00:00
Time Out

	Address	City/State	Zip Code	Telephone
St John Home Care Llc	10805 South Shore Drive	Plymouth, MN	55441	9523001067

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038806		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

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

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

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 08/27/24

Inspector (Signature) Gary King