



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

November 21, 2024

Licensee

Obed-Edom Assisted Living
7388 Symphony Street Northeast
Fridley, MN 55432

RE: License Number 413774
Health Facility Identification Number (HFID) 37133
Project Number(s) SL37133015

Dear Licensee:

On October 28, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed June 12, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective November 21, 2024.

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the survey completed on June 12, 2024.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on October 28, 2024, found not corrected at the time of the follow-up and/or subject to a penalty assessment are as follows:

1640 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (a-E)
1890 - Prescription Drugs - 144g.71 Subd. 20

The details of the violations noted at the time of this follow-up survey completed on October 28, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **no immediate fines are assessed.**

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/28/2024
NAME OF PROVIDER OR SUPPLIER OBED-EDOM ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7388 SYMPHONY STREET NE FRIDLEY, MN 55432			
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL37133015-1 On October 28, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 12, 2024. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480	Not reviewed during this survey.		
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. This MN Requirement is not met as evidenced by:	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,	0 810			

Minnesota Department of Health

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0 810	Continued From page 2 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810	Not reviewed during this survey.		
01640 SS=D	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	01640			

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01640	Continued From page 3 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 the service plan included a resident or resident representative's signature to document agreement on the services to be provided for one of three residents (R5). This practice resulted in a level two 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 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: R5's service plan dated October 28, 2024, indicated R5's services included assistance medication administration, meals, laundry, and housekeeping. R5's service plan lacked a resident or resident	01640			

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01640	Continued From page 4 representative signature to document agreement on the services to be provided. On October 28, 2024, at 3:05 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R5 did not have a signed service plan in his record because he had forgotten to print the service plan and have it signed. The licensee's Service Plan policy dated July 21, 2022, indicated the initial service plan and any revisions are signed by a representative from licensee and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of three residents (R3). This practice resulted in a level two violation (a	01890			

Minnesota Department of Health

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01890	Continued From page 5 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: On October 28, 2024, at 1:18 p.m., the surveyor observed the locked medication cabinet with unlicensed personnel (ULP)-C and observed the following expired medications for R3: - hydroxyzine 50 milligrams (mg) with an expiration date of October 1, 2024. On October 28, 2024, at 1:18 p.m., ULP-C confirmed the expiration date with the surveyor. On October 28, 2024, at 1:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he agreed the medication for R3 was expired and he checks for expired medications weekly but must have missed this medication. The licensee's Disposition and Disposal of Medications policy dated July 21, 2022, indicated discontinued medications may be kept until the expiration dates if there is a possibility of resuming the medication. If not resumed before the expiration date, it will be disposed of according to this policy. Any medications, other than controlled substances, under the licensee storage after the termination of the medication management program for a resident, that are discontinued or expired or upon a resident's death will be disposed of by a licensed nurse	01890			

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01890	Continued From page 6 according to instructions provided on the drug label. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

July 22, 2024

Licensee
Obed-Edom Assisted Living
7388 Symphony Street Northeast
Fridley, MN 55432

RE: Conditional License Number 413774
Health Facility Identification Number (HFID) 37133
Project Number(s) SL37133015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **October 20, 2024**.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

CONDITIONAL LICENSE ISSUED:

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

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

- a. No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. No new admissions:** Obed-Edom Assisted Living will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Obed-Edom Assisted Living must provide the Department:
 - i. A list of the names and birthdates of any individuals Obed-Edom Assisted Living is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 1. Name and birthdate of each resident

2. Physical location of each resident
 3. Current payment source for services
 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Obed-Edom Assisted Living will contract with an RN to provide consultation concerning all resident(s) to whom Obed-Edom Assisted Living provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Obed-Edom Assisted Living. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Obed-Edom Assisted Living and MDH must review the RN's credentials and approve the selection. Obed-Edom Assisted Living is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Obed-Edom Assisted Living in an effort to help Obed-Edom Assisted Living align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Obed-Edom Assisted Living 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 Obed-Edom Assisted Living and the RN consultant about a change. Each report will be electronically submitted to Kelly Thorson, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at kelly.thorson@state.mn.us. Kelly Thorson can be reached at 320-223-7336 (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 assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family

- members are treated;
- vii. Concerns; and
- viii. Any other information requested by the Department or considered important by the RN consultant(s).

- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Obed-Edom Assisted Living to correct the violations cited during the survey as well as to determine the overall practice of Obed-Edom Assisted Living in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up 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 license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** Obed-Edom Assisted Living 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 Obed-Edom Assisted Living 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 Obed-Edom Assisted Living is in substantial compliance on the follow up survey, MDH will remove the conditions from Obed-Edom Assisted Living's assisted living facility license, and Obed-Edom Assisted Living will correct any outstanding violations identified during the survey. If Obed-Edom Assisted Living is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee

receives notice of the action. To submit a hearing request, please visit
<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

If you have any questions, please contact Kelly Thorson directly at: 320-223-7336.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, slightly slanted style.

Rick Michals, J.D.

Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37133015-0 On June 10, 2024, through, June 12, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 resident(s); 4 receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
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			

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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 ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 June 10, 2024, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A	0 250			

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0 250	Continued From page 3 stated they were familiar with the current assisted living laws and regulations. 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 (opens in a new window), 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 may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the	0 250			

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0 250	Continued From page 4 requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or maybe 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, 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 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	0 250			

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0 250	Continued From page 5 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. - I attest that the assisted living facility has provided services to at least one resident during the immediately preceding license year as required by Minn. Stat. sect. 144G.17 (5). Page six was electronically signed by the authorized agent on July 18, 2023. The licensee had an assisted living license, effective November 11, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs, 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; - orientation to implementation of the assisted living Bill of Rights; - conducting appropriate screenings, or	0 250			

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0 250	Continued From page 6 documentation of prior screenings, to show that staff were free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention of Standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated task. As a result of the survey, the following correction orders were issued, 0470, 0480, 0550, 0630, 0650, 0660, 0680, 0800, 0810, 1370, 1380, 1440, 1500, 1620. 1640, 1710, 1720, 1770, 1780, 1820, 1830, 1850, 1890, 2290, 2320, 2400, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
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;	0 470			

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0 470	Continued From page 7 (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; (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 interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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: The licensee held an assisted living license and was licensed for a capacity of five residents and had a current census of four residents.	0 470			

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0 470	Continued From page 8 On June 10, 2024, at 10:30 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they do not currently have a staffing plan all they have is the schedule. The licensee's Staffing policy dated July 21, 2022, indicated the staffing plan to determine the required staffing level is prepared by the clinical nurse supervisor. The staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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: (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	0 480			

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0 480	Continued From page 9 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 June 10, 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			
0 550 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	0 550			

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0 550	Continued From page 10 information related to the grievance procedure. This had the potential to affect all the licensee's 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) 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: On June 10, 2024, at 10:30 a.m., during the entrance conference, the surveyor did not observe information about the licensee's complaint/grievance procedure, the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. On June 10, 2024, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the complaint procedure or form is not posted anywhere but the residents have a copy in their record they were advised of the compliant procedure on admission. The licensee's Grievance policy dated July 21, 2022, indicated a copy of the grievance procedure is conspicuously posted in the residents with the following information: -name, phone number and e-mail contact information for the individuals who are responsible for handling resident complaints. No further information was provided.	0 550			

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0 550	Continued From page 11	0 550			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: R1	0 630			

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0 630	Continued From page 12 R1 was admitted to the licensee on February 22, 2023. R1's IAPP dated February 22, 2023, indicated R1 was not at risk to be abused and not at risk of abusing others but did not include: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2 was admitted to the licensee on November 1, 2022. R2's IAPP dated November 1, 2022, indicated R2 was not at risk to be abused and not at risk of abusing others but did not include: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On June 10, 2024, at 3:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he agreed the IAPP requirements are not met on the current IAPP's for all of the residents in the facility and will need to update them. The licensee's Vulnerable Adult Policy dated July 21, 2022, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. - The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults; - The plan shall contain the resident's risk of abusing other vulnerable adults; - The plan shall contain statements of specific	0 630			

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0 630	Continued From page 13 measures to be taken to minimize the risk of abuse to that person and other vulnerable adults; and - The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual 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.	0 650			

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0 650	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-C and ULP-D). 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-C ULP-C was hired to provide direct care services for the licensee on November 22, 2022. On June 10, 2024, at 3:30 p.m., the surveyor observed ULP-C administer R4's medications. ULP-D ULP-D was hired to provide direct care services for the licensee on November 1, 2022. ULP-C and ULP-D's employee records lacked an annual performance review for the 2023 year of employment with the licensee. On June 12, 2024, at 3:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the performance reviews were not in the employee records and he forgot to document the annual performance reviews for the	0 650			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 15 staff. The licensee's Performance Evaluation policy dated July 21, 2022, indicated formal performance evaluation will be conducted for all staff providing assisted living services at least annually. Documentation of the annual performance evaluation will be maintained in the personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and	0 660			

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0 660	Continued From page 16 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment. In addition, the licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of two employees, (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RISK ASSESSMENT On June 10, 2024, at 1:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the last TB facility risk assessment was completed on March 7, 2023, and he was a couple of months behind on filling out the new facility risk assessment. The licensee's Tuberculosis Screening/Prevention policy dated July 21, 2022, indicated the director is responsible for conducting the formal TB Risk Assessment and updating it annually. TB SCREENING ULP-C ULP-C was hired to provide direct care services for the licensee on November 22, 2022.	0 660			

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0 660	Continued From page 17 ULP-C's employee record included one tuberculin skin test (TST) completed on November 29, 2022, however lacked a tuberculosis (TB) screening to include a second step TST tuberculin skin test or other evidence of a TB screening such as a blood test. On June 10, 2024, at 3:30 p.m., the surveyor observed ULP-C administer R4's medications. On June 12, 2024, at 2:15 p.m., LALD/CNS-A stated ULP-C was missing the second step of the TB test and they did not realize the second step was missing. Tuberculosis Screening/Prevention policy dated July 21, 2022, indicated baseline testing is completed on hire for all direct care providers and anyone who visits residents. - Employees receive baseline TB screening upon higher to test for infection with M. Tuberculosis; - Baseline screening includes an assessment for TB history and current TB symptoms; - An employees history of BCG vaccination will be disregarded when administering and interpreting TST results; - If the first step TST is negative, the second step TST will be administered 1-3 weeks after the first TST result was read; - If the first and second step TST results are both negative, the person is classified as not infected with M. Tuberculosis. Additional TB screening is not necessary unless an exposure to M. Tuberculosis occurs; and - Written documentation for all TST results includes the millimeter induration, the interpretation (either positive or negative), the date read and a signature on letterhead.	0 660			

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0 660	Continued From page 18 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 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." "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680			

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0 680	Continued From page 19 (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 interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 11, 2024, at 9:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided the evaluator with a binder that contained the emergency preparedness manual and indicated the contents were the licensee's EP plan.	0 680			

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0 680	Continued From page 20 The licensee's undated emergency preparedness plan (EPP), lacked the required content: - develop and maintain the EPP; - maintain annual updates; - identify program patient population; - a process for emergency preparedness (EP) collaboration with local, tribal, regional, State and Federal EP officials to maintain integrated response; - the development of policies/procedures to address: - subsistence needs for staff and patients; - procedures for tracking staff and residents; - use of volunteers; - arrangement with other facilities; and - roles under a waiver declared by the secretary. - a communication plan that included: - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, state licensing and certification agency, or the ombudsman for long term care; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or a designee; and - a quarterly review of missing resident policy. On June 11, 2024, at 11:20 a.m., LALD/CNS-A agreed their emergency preparedness plan was missing some of the required content.	0 680			

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0 680	Continued From page 21 The licensee's Emergency Preparedness policy dated July 21, 2022, indicated the facility will have identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated July 21, 2022, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment	0 800			

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0 800	Continued From page 22 in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the 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). Findings include: On June 10, 2024, survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, and observed the following maintenance issues: 1. The dining, kitchen and bedroom floors were sticky and soiled and could use a cleaning. 2. Baseboards and windowsills had dead insects and dirt on them and could use a cleaning. 3. The sliding screen door on the back deck patio area does not open and shut properly, it is also missing the weather stripping. 4. Resident bedrooms #3, and #4 have the ceiling vent covers coming down. 5. Resident bedrooms #2, #3 and #4 and #5 have objects such as bedframes, in front of and blocking the egress window. 6. Resident Bedroom #3 had burnt incense sticks and ashes all over the wall ledge. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 800			

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0 800	Continued From page 23 (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The 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.	0 810			

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0 810	Continued From page 24 This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 11, 2024, at 9:42 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents via email on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency as well as complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan needs to be updated to the facilities current setup.	0 810			

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0 810	Continued From page 25 Record review of the available documentation indicated that the licensee did not provide training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed one evacuation drill in February 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
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; (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	01370			

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01370	Continued From page 26 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 observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-C and ULP-D). 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:	01370			

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01370	Continued From page 27 ULP-C ULP-C was hired to provide direct care services to residents on November 22, 2022. On June 10, 2024, at 3:30 p.m., the surveyor observed ULP-C administer R4's medications. ULP-C's employee record lacked the following competency evaluations: - basic infection control, including blood-borne pathogens; - standby assistance techniques and how to perform them; and - 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. ULP-D ULP-D was hired to provide direct care services to residents on November 1, 2022. ULP-D's employee record lacked the following competency evaluations: - basic infection control, including blood-borne pathogens; - standby assistance techniques and how to perform them; and - 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. On June 12, 2024, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated some of the training and competency topics were missing from the unlicensed staff records and this would be the case for all staff due to using the same training	01370			

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01370	Continued From page 28 materials for all staff. LALD/CNS-A stated he is unsure why these topics are missing from the packets. The licensees Staff Competency policy dated July 21, 2022, indicated training and competency evaluations for all unlicensed personnel must include the following: - Basic infection control, including blood-borne pathogens; - Standby assistance techniques and how to perform them; and - 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. 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			

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01380	Continued From page 29 (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 observation, interview, and record review, the licensee failed to ensure training and competency evaluations for the required topics were completed for two of two employees (unlicensed personnel (ULP)-C and ULP-D). 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-C ULP-C was hired to provide direct care services to residents on November 22, 2022. On June 10, 2024, at 3:30 p.m., the surveyor observed ULP-C administer R4's medications. ULP-C's record lacked evidence of training prior to providing services for the following: -observation, reporting, and documenting of client status. ULP-D ULP-D was hired to provide direct care services to residents on November 1, 2022.	01380			

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NAME OF PROVIDER OR SUPPLIER OBED-EDOM ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7388 SYMPHONY STREET NE FRIDLEY, MN 55432		
(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 30 ULP-D's record lacked evidence of training prior to providing services for the following: -observation, reporting, and documenting of client status. On June 12, 2024, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated some of the training and competency topics were missing from the unlicensed staff records and this would be the case for all staff due to using the same training materials for all staff. LALD/CNS-A stated he is unsure why these topics are missing from the packets. The licensee's Staff Competency policy dated February 17, 2022, indicated home health aides may not work for the licensee until they have successfully past the written and demonstration competency evaluation including satisfactory completion of the following: - Observation, reporting and documenting of resident status. No further information 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	01440			

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01440	Continued From page 31 and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse completed delegated task supervision within 30 calendar days for two of two employees (unlicensed personnel (ULP)-C and ULP-D) who performed delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired to provide direct care services to residents on November 22, 2022.	01440			

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01440	Continued From page 32 On June 10, 2024, at 3:30 p.m., the surveyor observed ULP-C administer R4's medications. ULP-D ULP-D was hired to provide direct care services to residents on November 1, 2022. ULP-C and ULP-D's records lacked evidence the registered nurse (RN) completed supervision of ULPs who performed delegated tasks within 30 calendar days. On June 11, 2024, at 3:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he did not complete the 30-day supervision with the staff and that was registered nurse (RN)-B's responsibility. On June 12, 2024, at 2:54 p.m., RN-B stated he completed the 30-day supervision with all of the staff but did not document this anywhere and so there is not evidence of the supervision in any of the employee records. The licensee's Supervision of Unlicensed Staff policy dated July 21, 2022, indicated direct supervision of home health aides performing delegated task will be provided within 30 calendar days after the individual begins working for the assisted living provider and thereafter as needed based on performance. The RN will document supervision in the employee's personnel file related to performance management. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			

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01500	Continued From page 33	01500			
01500 SS=F	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 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.	01500			

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01500	Continued From page 34 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 observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-C and ULP-D). 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: ULP-C	01500			

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01500	Continued From page 35 ULP-C was hired to provide direct care services to residents on November 22, 2022. On June 10, 2024, at 3:30 p.m., the surveyor observed ULP-C administer R4's medications. ULP-C's record lacked documentation of annual training to include: - Review of provider's policies and procedures. ULP-D ULP-D was hired to provide direct care services to residents on November 1, 2022. ULP-C's record lacked documentation of annual training to include: - Review of provider's policies and procedures. On June 12, 2024, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all the employees are missing the annual training on the review of the policies and procedures. The licensee's Staff Orientation and Education policy dated July 21, 2022, indicated all staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. Education topics will include, but not be limited to: - Review of the organizations policies and procedures related to provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

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01620	Continued From page 36	01620			
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 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 observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing 14-day resident reassessment for one of two residents (R1) and failed to conduct ongoing nursing assessments not to exceed 90 calendar days and failed to use the uniform assessment tool for two of two residents (R1, and R2). This practice resulted in a level two violation (a	01620			

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01620	Continued From page 37 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: R1 R1 was admitted to the licensee on February 22, 2023. R1's diagnoses included alcohol use disorder, anxiety, depression, and posttraumatic stress disorder. R1's unsigned service plan dated February 22, 2023, indicated R1 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R1's record included an admission assessment dated February 22, 2023, however, R1's record did not contain a 14-day assessment. R1's following 90-day assessments all exceeded 90 calendar days. All of these assessments lacked all the required elements on the uniform assessment tool. The following R1 90-day assessments were completed late or missing: - June 6, 2023, by 14 days; - September 6, 2023, by 2 days; - December 6, 2023, by 1 day; - March 6, 2024, by 1 day; and - June 3, 2024, missing by 10 days.	01620			

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01620	Continued From page 38 On June 11, 2024, at 12:00 p.m., the surveyor observed unlicensed staff (ULP)-C making lunch for all the residents. On June 12, 2024, at 10:15 a.m., R1 stated the staff here make him food and take him to appointments. R2 R2 was admitted to the licensee on November 1, 2022. R2's diagnoses included anxiety, depression, and iron deficiency. R2's unsigned service plan dated February 1, 2023, indicated R2 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R2's following 90-day assessments all exceeded 90 calendar days. All of these assessments lacked all the required elements on the uniform assessment tool. The following R2 90-day assessments were completed late: - February 15, 2023, by 2 days; - May 15, 2023, by 1 day; - August 15, 2023, by 2 days; - November 15, 2023, by 2 days; and - February 15, 2024, by 2 days. On June 11, 2024, R2 stated the staff here make her meals and give her medicine. On June 10, 2024, at 3:02 p.m., the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they use the uniform	01620			

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01620	Continued From page 39 assessment tool on the admission assessment but only use the one-page monitoring and reassessment form for all the 14 day and 90-day visits because the residents do not have many changes. LALD/CNS-A also stated the 14-day assessment for R1 must have been missed and the other assessments are a few days late due to the other registered nurse (RN)-B missed the due date. On June 12, 2024, at 2:54 p.m., RN-B stated the assessments were late because he missed the due date. The licensee's Assessment and Reassessment policy dated July 21, 2022, indicated the RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. Ongoing resident re assessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. The licensee's Comprehensive Nursing Assessment dated July 21, 2022, indicated the RN will conduct a comprehensive assessment utilizing a uniform assessment tool. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=E	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.	01640			

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01640	Continued From page 40 (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 observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident to document agreement on the services to be provided for two of two residents (R1 and 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 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).	01640			

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01640	Continued From page 41 The findings include: R1 R1's Service Plan dated February 22, 2023, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. On June 11, 2024, at 12:00 p.m., the surveyor observed unlicensed staff (ULP)-C making lunch for all the residents. On June 12, 2024, at 10:15 a.m., R1 stated the staff here make him food and take him to appointments. R2 R2's Service Plan dated February 1, 2023, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. On June 11, 2024, R2 stated the staff here make her meals and give her medicine. On June 10, 2024, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he is not sure why the service plans for R1 and R2 are not signed, he must have forgotten to make sure they were signed before adding them to their record. The licensee's Service Plan policy dated July 21, 2022, indicated the initial service plan and any revisions are signed by a representative from licensee and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided.	01640			

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01640	Continued From page 42	01640			
	TIME PERIOD TO CORRECT- Twenty-one (21) days				
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication re-assessments for two of two residents (R1 and 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) 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 R1 was admitted to the licensee on February 22, 2023. R1's diagnoses included alcohol use disorder, anxiety, depression, and posttraumatic stress disorder.	01710			

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01710	Continued From page 43 R1's unsigned service plan dated February 22, 2023, indicated R1 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R1's Medication Assessment and Management Plan dated February 22, 2023, was indicated by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A as R1's last annual medication management review. R2 R2 was admitted to the licensee on November 1, 2022. R2's diagnoses included anxiety, depression, and iron deficiency. R2's unsigned service plan dated February 1, 2023, indicated R2 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R2's Medication Assessment and Management Plan dated November 1, 2022, was indicated by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A as R2's last annual medication management review. On June 12, 2024, at 2:54 p.m., registered nurse (RN)-B stated he competed a medication assessment with the resident's more than annually but does not document this anywhere. The licensee's Assessment of Medications policy dated July 21, 2022, indicated medication reassessment will occur at the following times: - Resident symptomology. - Problems or concerns that may be medication	01710			

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NAME OF PROVIDER OR SUPPLIER OBED-EDOM ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7388 SYMPHONY STREET NE FRIDLEY, MN 55432			
(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
01710	Continued From page 44 related. - With new prescription, over the counter (OTC) or herbal products. - Annually. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01720 SS=F	144G.71 Subd. 4 Resident refusal The assisted living facility must document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to discuss with the resident the possible consequences of the resident's medication refusal and document the discussion in the resident's record for two of four residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01720			

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01720	Continued From page 45 R1 R1 was admitted to the licensee on February 22, 2023. R1's diagnoses included alcohol use disorder, anxiety, depression, and posttraumatic stress disorder. R1's unsigned service plan dated February 22, 2023, indicated R1 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R1's Medication Administration Record (MAR) dated May 1, 2024, through May 31, 2024, indicated R1 had refused the medications all 31 days. R1's MAR dated June 1, 2024, through June 11, 2024, indicated R1 had refused the medications 10 of the 11 days. The MAR lacked reason for refusal and education provided to the resident by the staff. R1's Resident Notes dated May 1, 2024, through June 11, 2024, lacked documentation of discussion and education provided to the resident by staff on possible consequences of the refusal of medications. R2 R2 was admitted to the licensee on November 1, 2022. R2's diagnoses included anxiety, depression, and iron deficiency. R2's unsigned service plan dated February 1, 2023, indicated R2 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping.	01720			

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01720	Continued From page 46 R2's Medication Administration Record (MAR) dated May 1, 2024, through May 31, 2024, indicated R2 had skipped the medications 29 out of 31 days. R1's MAR dated June 1, 2024, through June 11, 2024, indicated R2 had skipped the medications 10 of the 11 days. The MAR lacked reason for refusal and education provided to the resident by the staff. R2's Resident Notes dated May 1, 2024, through June 11, 2024, lacked documentation of discussion and education provided to the resident by staff on possible consequences of the refusal of medications. On June 11, 2024, at 10:00 a.m., unlicensed personnel (ULP)-C stated R1 never takes his medications. On June 11, 2024, at 2:44 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the other registered nurse is responsible for updating the doctor about resident medication refusals and discussing the consequences of refusals with the resident. On June 12, 2024, at 2:54 p.m., registered nurse (RN)-B stated they had discussed the consequences of not taking the medications as prescribed with the residents and he advised the provider of the refusals, but this has not been documented anywhere. The licensee's Medication Documentation policy dated July 21, 2022, indicated if the administration of one or more medications was not completed, staff will document the following: - The reason why the medication was not administered;	01720			

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01720	Continued From page 47 - Follow up procedures to meet the residents needs in compliance with the medication management plan; - Appropriate notification to RN supervisor or other persons as instructed regarding missed dosages; and - Medication error report, if appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01720			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (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) 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:	01770			

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01770	Continued From page 48 During the entrance conference on June 10, 2024, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the nurse sets up all medications for residents in medication bars for the staff to administer the medications from but they currently do not document this medication set up anywhere, but the nurse uses the medication administration record (MAR) to fill the medication bar. R2's diagnoses included anxiety, depression, and iron deficiency. R2's service plan dated February 1, 2023, indicated R2 received services which included medication administration, bathing assistance, dressing assistance, meals, and housekeeping/laundry. R2's medication assessment and management plan dated November 1, 2022, indicated R2 received set-up of medication in medi-planner by facility nurse. On June 12, 2024, at 10:45 a.m., the surveyor observed the locked medication cabinet with unlicensed staff (ULP)-C and noted R2's had medications that were in bottles and also had a partially filled weekly medication bar the staff administered her medications from. The licensee's Medication Documentation policy dated July 21, 2022, indicated the licensee will document medication set up according to the following: -date of medication setup; -name of medication; -quantity of dose;	01770			

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01770	Continued From page 49 -times to be administered; -route of administration; and -name/title of person completing medication setup. Documentation of medication administration and medication set up will be completed promptly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures for giving accurate and current medications for those residents who received medication management services during planned times away from home. This had the potential to affect five residents receiving medication management services.	01780			

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01780	Continued From page 50 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 June 10, 2024, at 10:30 a.m. registered nurse (RN)-B stated the unlicensed staff do not document the medications that are sent with residents on a leave of absence (LOA) they will write down how many days of the medications they sent with the resident in a communication book and put the medications in envelopes and label the envelopes for the resident. On June 10, 2024, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated medications sent out of facility with residents are not currently documented anywhere. The licensee's Medication Management Plan for Residents Away from Home dated July 21, 2022, indicated for unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the registered nurse in a timely manner, the registered nurse may delegate to an unlicensed personnel to provide the medications based on the following: -the registered nurse has trained the home health aide and determined the home health aid	01780			

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01780	Continued From page 51 competency to follow procedures for giving medications to residents; -the registered nurses instructed the home health aide to ensure that all appropriate precautions are taken; -the registered nurse has developed written procedures/protocols for the home health aide, including special instructions regarding controlled substances; -how the RN should be notified that the medications were provided and whether the RN should be notified before the medications are given to the resident or designated representative; and -medications may be set up for the length of the anticipated absence, not to exceed seven calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780			
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 observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of two residents (R1 and R4). This practice resulted in a level two violation (a	01820			

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01820	Continued From page 52 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: R1 was admitted to the licensee on February 22, 2023. R1's diagnoses included alcohol use disorder, anxiety, depression, and posttraumatic stress disorder. R1's unsigned service plan dated February 22, 2023, indicated R1 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R1's record lacked authenticated current prescription orders for all medications managed by licensee. R4 R4 was admitted to the licensee on April 16, 2024. R4's service plan dated April 16, 2024, indicated R4 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R4's record lacked authenticated current prescription orders for all medications managed by licensee. On June 10, 2024, at 3:30 p.m., the surveyor	01820			

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01820	Continued From page 53 observed unlicensed personnel (ULP)-C administer R4's PRN medication. On June 11, 2024, at 2:44 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the orders he provided were sent from the pharmacy today because he wanted to provide the most recent orders and was unable to locate any of them in the resident's records. The licensee's Medication Orders policy dated July 21, 2022, indicated the licensee will maintain a current written or electronic recorded prescription for all prescribed medications managed for the resident. No further information provider. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01830			

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01830	Continued From page 54 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: R1 was admitted to the licensee on February 22, 2023. R1's diagnoses included alcohol use disorder, anxiety, depression, and posttraumatic stress disorder. R1's unsigned service plan dated February 22, 2023, indicated R1 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R2 R2 was admitted to the licensee on November 1, 2022. R2's diagnoses included anxiety, depression, and iron deficiency. R2's unsigned service plan dated February 1, 2023, indicated R2 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R1 and R2's medical record lacked annual signed provider orders. On June 11, 2024, at 3:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he does not have annual	01830			

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01830	Continued From page 55 orders for R1 and R2. On June 12, 2024, at 2:54 p.m., registered nurse (RN)-B stated they do not currently send a medication list to the provider to sign annually and did not realize there was a report in their electronic charting system to use for this but will utilize this and get annual orders signed. The licensee's Medication Orders policy dated July 21, 2022, indicated medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01850 SS=D	144G.71 Subd. 16 Written or electronic prescription When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the resident's record. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were communicated to the registered nurse (RN) 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	01850			

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01850	Continued From page 56 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on February 22, 2023. R1's diagnoses included alcohol use disorder, anxiety, depression, and posttraumatic stress disorder. R1's unsigned service plan dated February 22, 2023, indicated R1 received services to include medication administration, dressing assistance, meals, laundry, and housekeeping. R1's MD orders dated April 25, 2024, indicated R1 was prescribed Naltrexone 50mg tablet once daily, hydroxyzine 25mg take one to two tablets by mouth as needed depending on anxiety level up to three times a day, and sertraline 25mg daily. R1's April, May, and June 2024 medication administration record (MAR) indicated R1 was prescribed Naltrexone 50 mg tablet once daily and hydroxyzine 25mg take one to two tablets by mouth as needed depending on anxiety level up to three times a day. R1's MAR lacked the medication sertraline 25mg daily. On June 12, 2024, at 2:54 p.m., registered nurse (RN)-B stated he must have accidentally deleted the sertraline from R1's MAR on Monday, when the survey started, and did not realize it happened. RN-B stated R1 refuses all of his	01850			

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01850	Continued From page 57 medications anyway, but he will work on getting this medication back on the MAR. The licensee's Medication Orders policy dated July 21, 2022, indicated when a written or Electronic Prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01850			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of four residents (R4). 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	01890			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER OBED-EDOM ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7388 SYMPHONY STREET NE FRIDLEY, MN 55432		
(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
01890	Continued From page 58 situation has occurred only occasionally). The findings include: On June 12, 2024, at 10:45 a.m., the surveyor observed the locked medication cabinet with unlicensed personnel (ULP)-C and observed the following expired medications for R4: - buspirone 15 milligram (mg) with an expiration date of December 6, 2023. On June 12, 2024, at 10:45 a.m., ULP-C confirmed the expiration date with the surveyor. On June 12, 2024, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he agreed the medication for R4 was expired, it was an old medication that R4 no longer took, and it must have been missed when the checks for expired medications are done every two months. The licensee's Disposition and Disposal of Medications policy dated July 21, 2022, indicated discontinued medications may be kept until the expiration dates if there is a possibility of resuming the medication. If not resumed before the expiration date, it will be disposed of according to this policy. Any medications, other than controlled substances, under the licensee storage after the termination of the medication management program for a resident, that are discontinued or expired or upon a resident's death will be disposed of by a licensed nurse according to instructions provided on the drug label. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
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01890	Continued From page 59 days	01890			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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 June 10, 2024, at 11:00 a.m., surveyor observed a sign posted in the living room on the wall beside the kitchen titled Rules for all Resident Living at Licensee. The sign read: 1. All resident is to be respectful to other resident living in the house. This includes not making loud noise, screaming and playing loud music. Play music is allowed but the volume is to be low or use earpiece. 2. Resident is not allowed into another residence	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
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02290	Continued From page 60 room and take things that do not belong to them. 3. Resident is not allowed to have visitors for now into the house due to COVID. 4. Resident is not allowed to smoke in the house and no alcohol drinks in their rooms. 5. Resident is not allowed to smoke weed in the house, their room, or the garage. 6. Resident is allowed to only smoke cigarette outside and not weed or else the police will be called to inspect the resident's room. 7. Resident will respect staff, listen to staff, and follow all rules. On June 12, 2024, at 3:30 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were not aware that you could not have house rules to restrict resident rights to use or possess alcohol and drugs at the facility. LALD/CNS-A stated some of the resident's have alcohol and drug restrictions due to legal reasons and this is why the rules are posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02290			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
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02320	Continued From page 61 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of one employee (ULP-C), observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired to provide direct care services to residents on November 22, 2022. ULP-C's employee record contained documentation that ULP-C had completed a medication administration competency evaluation with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on November 22, 2022. On June 10, 2024, at 3:30 p.m., the surveyor observed ULP-C perform medication administration for R4 when they requested an as needed medication. ULP-C went to the locked medication cabinet and opened a separate locked box and obtained a punch pack for R4 that contained lorazepam 0.5 mg oral tablets and punched one of the tablets out of the punch pack into a medication cup. ULP-C administered the medication to R4.	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
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02320	Continued From page 62 On June 10, 2024, at 3:35 p.m., ULP-C stated they would normally look at the medication administration record (MAR) before administering a medication but she did not today because the registered nurse was right there. On June 10, 2024, at 3:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they would expect the staff to look at a MAR before administering medications. The licensee's Supervision: Unlicensed Staff policy date July 21, 2022, indicated home health aides providing services to assisted living residents we'll be supervised to assure that the work is being performed competently and to identify problems and solutions to address issues relating to the employee's ability to provide the services to residents of licensee. Supervision includes verification that the work is being performed competently and problems/solutions related to the home health aide's ability to perform the task are identified. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02400 SS=C	144G.91 Subd. 12 Visitors and social participation (a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
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02400	Continued From page 63 choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. (b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to respect the resident's right to receive visits at any time. This had the potential to affect all residents at the facility. 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: On June 10, 2024, at 11:00 a.m., the surveyor observed a sign posted in the living room on the wall beside the kitchen titled Visitor Rules and Policies. The sign read: 1. No visitor can sleep over. 2. Visitors should show ID and sign in visitors log on arrival and leaving. 3. Visitors cannot carry any weapons or illegal substances.	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
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02400	Continued From page 64 4. No visitor under substance influence is allowed in the house. 5. No noise in the house during sleeping hours. Call the manager or supervisor with any questions. On June 12, 2024, at 3:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was unaware that you could not restrict visitors. LALD/CNS-A stated he recently put the sign up because one of the resident's brought a male visitor that was intoxicated home with her and it scared the staff. The licensee's undated Bill of Rights indicated residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, healthcare agent attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02400			

Type: Full
Date: 06/10/24
Time: 11:00:00
Report: 1031241150

Food and Beverage Establishment Inspection Report

Page 1

Location:

OBED-EDOM Assisted Living
7388 Symphony Street Ne
Fridley, MN55432
Anoka County, 02

Establishment Info:

ID #: 0037758
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128881277
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

ESTABLISHMENT DID NOT HAVE ILLNESS LOG ON SITE. COPY OF LOG SENT WITH REPORT.
PRINT AND KEEP ILLNESS LOG ON SITE AND UP TO DATE.

Comply By: 06/10/24

3-800 Highly Susceptible Populations

3-801.11B

**** Priority 1 ****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

UNPASTEURIZED EGGS BEING SERVED "ANY STYLE." ***DISCONTINUE PRACTICE.***
UNPASTEURIZED EGGS TO ONLY BE COOKED TO 145F.

Comply By: 06/10/24

4-700 Sanitizing Equipment and Utensils

4-703.11B

**** Priority 1 ****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

UTENSIL TEMPERATURE DISH MACHINE MEASURED 150F. **DISCONTINUE USING DISH MACHINE FOR SANITIZING UNTIL REPAIRED.** CAN BE USED FOR WASH/RINSE. FILL SINK WITH SANITIZER WATER (50-200PPM) AND DIP DISHES AFTER WASHING. ALLOW DISHES

Type: Full
Date: 06/10/24
Time: 11:00:00
Report: 1031241150
Grace Assisted Living Llc

Food and Beverage Establishment Inspection Report

Page 2

TO AIR DRY.

Comply By: 06/11/24

3-500C Microbial Control: date marking

3-501.17A ** Priority 2 **

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

TURKEY AND POTATO SALAD NOT DATE MARKED. DISCUSSED DATE MARKING WITH STAFF AND HAD THEM ADD DATE MARKS TO ITEMS.

Comply By: 06/10/24

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.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE OR WAX TEST STRIPS.
PROVIDE IRREVERSIBLE MEASURING DEVICE OR WAX STRIPS AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 06/14/24

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)

Comply By: 06/13/24

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

1. CAN OPENER FOUND WITH FOOD BUILDUP ON BLADE.

2. THIN PROBE THERMOMETER GREASY/TACKY.

DISCUSSED REASON BEHIND CLEANING FOOD CONTACT ITEMS. CLEAN AND MAINTAIN CLEAN ALL FOOD CONTACT ITEMS AND SURFACES.

Comply By: 06/13/24

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).
ESTABLISHMENT DOES HAVE SAFESERV OR SIMILAR COMPLETED.

Comply By: 06/10/24

Type: Full
Date: 06/10/24
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Food and Beverage Establishment Inspection Report

Page 3

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

2 SPATULAS WITH PLASTIC DETATCHING FOUND IN UTENSIL DRAWER. ***SPATULAS DISCARDED*** REMOVE FROM SERVICE ALL DAMAGED UTENSILS THAT ARE UNCLEANABLE OR MAY CAUSE PHYSICAL CONTAMINATION.

Comply By: 06/24/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

2 KITCHEN DRAWERS HAVE HANDLES MISSING SCREWS. REINSTALL HANDLES.

Comply By: 07/01/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

1. COUNTERS AND COUTNER BACKSPLASH DIRTY/TACKY. MOVE ITEMS AND CLEAN. CLEAN ALL COUNTERS DAILY.
2. CUPBOARD INTERIORS DIRTY. CLENA CUPBOARD INTERIORS.
3. CUPBOARDS HAVE GREASE ON FACES. CLEAN CUPBOARD FACES.
4. CLEAN LIGHT SWITCHES AND OUTLETS.

Comply By: 06/14/24

Surface and Equipment Sanitizers

Chlorine: = 100 at Degrees Fahrenheit

Location: Sani Spray

Violation Issued: No

Dimethyl Ethyl Benzyl Ammo: > 400 at Degrees Fahrenheit

Location: Lysol Spray

Violation Issued: Yes

Dimethyl Ethyl Benzyl Ammo: = 50 at Degrees Fahrenheit

Location: Clorox Wipes

Violation Issued: Yes

Hot Water: = at 150 Degrees Fahrenheit

Location: Dish Machine

Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/Deli Turkey

Temperature: 38 Degrees Fahrenheit - Location: Refrigerator

Violation Issued: No

Type: Full
Date: 06/10/24
Time: 11:00:00
Report: 1031241150
Grace Assisted Living Llc

Food and Beverage Establishment Inspection Report

Page 4

Process/Item: Cold Hold/Pizza

Temperature: 65 Degrees Fahrenheit - Location: Tray in Oven (TPHC)

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		3	4	4

All violations discussed with PIC during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Staff must prepare sanitizer bucket or squirt bottle daily. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.
- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.
- Make sure to datemark any prepared cold items that are kept in refrigerator.
- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.
- 2-Comp sink has right basin designated for handwashing and the right basin for product washing/prep sink.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031241150 of 06/10/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Dereje Dinka
Person in Charge

Signed: _____

Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031241150

m

DEPARTMENT OF HEALTH

Environmental Health

Food, Pools, and Lodging

625 Robert St. N

St. Paul

No. of RF/PHI Categories Out

5

Date

06/10/24

No. of Repeat RF/PHI Categories Out

0

Time In

11:00:00

Legal Authority MN Rules Chapter 4626

Time Out

Grace Assisted Living Llc

Address

7388 Symphony Street Ne

City/State

Fridley, MN

Zip Code

55432

Telephone

6128881277

License/Permit #

0037758

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

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 complianceOUT= not in complianceN/O= not observedN/A= not applicableCOS= corrected on-site during inspectionR= repeat violation

Compliance Status

COS

R

Surpervision

1INOUTPIC knowledgeable; duties & oversight

2INOUTN/ACertified food protection manager, duties

Employee Health

3INOUTMgmt/Staff;knowledge,responsibilities&reporting

4INOUTProper use of reporting, restriction & exclusion

5INOUTProcedures for responding to vomiting & diarrheal events

Good Hygenic Practices

6INOUTN/OProper eating, tasting, drinking, or tobacco use

7INOUTN/ONo discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8INOUTN/OHands clean & properly washed

9INOUTN/ANo bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10INOUTAdequate handwashing sinks supplied/accessible

Approved Source

11INOUTFood obtained from approved source

12INOUTN/AN/OFood received at proper temperature

13INOUTFood in good condition, safe, & unadulterated

14INOUTN/AN/OREquired records available; shellstock tags, parasite destruction

Protection from Contamination

15INOUTN/AN/OFood separated and protected

16INOUTN/AFood contact surfaces: cleaned & sanitized

17INOUTProper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18INOUTN/AN/OProper cooking time & temperature

19INOUTN/AN/OProper reheating procedures for hot holding

20INOUTN/AN/OProper cooling time & temperature

21INOUTN/AN/OProper hot holding temperatures

22INOUTN/AFood cold holding temperatures

23INOUTN/AN/OProper date marking & disposition

24INOUTN/AN/OTime as a public health control: procedures & records

Consumer Advisory

25INOUTN/AConsumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26INOUTN/AFood pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27INOUTN/AFood additives: approved & properly used

28INOUTToxic substances properly identified, stored, & used

Conformance with Approved Procedures

29INOUTN/ACompliance with variance/specialized process/HACCP

Risk factors (RF) are improper practices or proceeedures 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 complianceMark "X" in appropriate box for COS and/or RCOS= corrected on-site during inspectionR= repeat violation

Safe Food and Water

30INOUTN/AFood pasteurized eggs used where required

31Water & ice obtained from an approved source

32INOUTN/AVariance obtained for specialized processing methods

Food Temperature Control

33Proper cooling methods used; adequate equipment for temperature control

34INOUTN/AN/OFood plant food properly cooked for hot holding

35INOUTN/AN/OFood approved thawing methods used

36Thermometers provided & accurate

Food Identification

37Food properly labled; original container

Prevention of Food Contamination

38Insects, rodents, & animals not present

39Contamination prevented during food prep, storage & display

40Personal cleanliness

41Wiping cloths: properly used & stored

42Washing fruits & vegetables

Proper Use of Utensils

43In-use utensils: properly stored

44Utensils, equipment & linens: properly stored, dried, & handled

45Single-use/single service articles: properly stored & used

46Gloves used properly

Utensil Equipment and Vending

47XFood & non-food contact surfaces cleanable, properly designed, constructed, & used

48XWarewashing facilities: installed, maintained, & used; test strips

49Non-food contact surfaces clean

Physical Facilities

50Hot & cold water available; adequate pressure

51Plumbing installed; proper backflow devices

52Sewage & waste water properly disposed

53Toilet facilities: properly constructed, supplied, & cleaned

54Garbage & refuse properly disposed; facilities maintained

55XPhysical facilities installed, maintained, & clean

56Adequate ventilation & lighting; designated areas used

57Compliance with MCIAA

58Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date: 06/11/24

Inspector (Signature)