Electronically Delivered

July 13, 2023

Licensee
Shamaani Assistant Living LLC
1873 Stinson Boulevard
New Brighton, MN 55112

RE: Project Number(s) SL38626015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on June 21, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

If you have any questions, please contact me.

Sincerely,

Jessica Sellner, Supervisor
State Evaluation Team
Email: jessica.sellner@state.mn.us
Telephone: 320-223-7370 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38626	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAMAANI ASSISTANT LIVING LLC	1873 STINSON BOULEVARD NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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: #SL38626015 On June 20-21, 2023, 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 and investigation, there were 3 residents receiving services under the provider's Provisional 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (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 ensure a staffing plan was developed for determining staffing levels as required and to post a daily staffing schedule in a central location. This had the potential to affect all residents receiving services from the licensee. 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	0 470		

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0 470	Continued From page 2 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). Findings include: The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. - Always ensured sufficient staffing 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 - ensured 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. On June 20, 2023, at 9:30 a.m., owner (OWN)-A stated the facility was staffed according to need and resident census. OWN-A stated the facility did not have a written plan in place to address staffing nor a daily posted staff schedule because the residents knew everyone who worked there. The licensee did not have a policy that specifically addressed staffing and staffing levels. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 470		

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0 480	Continued From page 3	0 480		
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 comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all three residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated June 20, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements	0 485		

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0 485	Continued From page 4 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee also failed to post a menu a week in advance and made available to residents. This had the potential to affect all residents receiving services from the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: On June 20, 2023, at 10:30 a.m., the surveyor	0 485		

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0 485	Continued From page 5 observed no weekly menu posted in a central area. The surveyor requested a copy of the week's menu. A menu was not provided, so the surveyor was unable to assess the nutritional qualities of the meals provided by the facility. On June 20, 2023, at 11:00 a.m., unlicensed personnel (ULP)-C stated the facility did not utilize a weekly menu. The licensee did not have a policy that specifically addressed creating and utilizing a weekly menu. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 485		
0 490 SS=C	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates	0 490		

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0 490	Continued From page 6 opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff provided daily social and recreational activities based on individual and group interests and physical, mental, and psychosocial needs that creates opportunities for active participation in the community. This had the potential to affect all three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: R1"s diagnoses included bilateral lower extremity weakness and swollen feet. R1 received services including assistance with activities of daily living, meals, housekeeping, laundry, and medication management. R1's care plan dated March 13, 2023, indicated R1 liked to take walks outside. R2's diagnoses included asthma, chronic obstructive pulmonary disease, depression, and bipolar disorder.	0 490		

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0 490	Continued From page 7 R2 received services including assistance with activities of daily living, meals, housekeeping, laundry, and medication management. R2's Resident Admission Information form dated March 21, 2023, indicated R2 liked to go on walks, color, and watch television. R3's diagnoses included bipolar disorder, anxiety, and depression. R3 received services including assistance with meals, housekeeping, laundry, and medication management. R3's Resident Admission Information form dated April 12, 2023, indicated R2 liked listening, to music, calling family and friends on the phone, reading the Bible, walking, and meditation. During the facility tour on June 20, 2023, at 10:30 a.m., no activity schedule was observed posted in the facility. When interviewed on June 20, 2023, at 9:30 a.m., owner (OWN)-A said the facility did not have written, scheduled, or planned activities for the residents of the facility. The licensee did not have a policy that specifically addressed creating and utilizing a calendar of planned social and recreational activities for residents. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	0 490		

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0 550	Continued From page 8	0 550		
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 document review, the licensee lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individual(s) who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all three residents (R1, R2, and R3) with records reviewed.	0 550		

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0 550	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During tour of the facility on June 20, 2023, at 10:30 a.m., the surveyor observed the common areas and did not see the required posting for grievance procedures with the required content and contact information for the state Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and for reporting suspected maltreatment to the MAARC. During an interview on June 20, 2023, at 9:30 a.m., owner (OWN)-A stated the required grievance notice content was not posted. The licensee's undated policy titled Complaint and Investigation Process indicated residents may contact the Office of the Ombudsman for Long-term Care with concerns regarding quality of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to	0 570		

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0 570	Continued From page 10 any person who requests it. This MN Requirement is not met as evidenced by: Based on interview, record review and observation, the licensee failed to post a copy of the current license at the main entrance of 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 the potential to affect a large portion or all the residents). Findings include: On June 20, 2023, at 10:30 a.m., the Minnesota Department of Health (MDH) began a provisional license survey. During a tour of the facility, the MDH surveyor observed there was no copy of the current assisted living license posted at the main entrance of the facility. When interviewed, owner (OWN)-A said there was a copy of the assisted living license posted in the office but not at the main public entrance. The licensee did not have a policy that specifically addressed required postings for the facility. TIME PERIOD TO CORRECT: Twenty-one (21) days.	0 570		
0 580 SS=C	144G.42 Subd. 2 Quality management	0 580		

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0 580	Continued From page 11 The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in quality management activity appropriate to the size of the facility and relevant to the type of services provided and failed to maintain documentation on quality management activities. This had the potential to affect all residents receiving services from the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: During the entrance conference interview on June 20, 2023, at 9:30 a.m., owner (OWN)-A verbalized familiarity with quality management	0 580		

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0 580	Continued From page 12 requirements in the assisted living statutes but said they did not have a quality management plan. The licensee's undated policy titled Quality Management Program indicated retention of reports of the Quality Team would be retained for two years and made available to the Minnesota Department of Health upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 580		
0 630 SS=D	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 ensure an individual abuse prevention plan (IAPP) for one of three residents (R1) included statements of specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults.	0 630		

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	38626	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAMAANI ASSISTANT LIVING LLC	1873 STINSON BOULEVARD NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 13 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's record lacked an individualized abuse prevention plan that included specific measures to minimize the risk of abuse to R1 and others. R1's diagnoses included bilateral lower extremity weakness and swollen feet. R1's care plan dated March 13, 2023, indicated R1 received services including assistance with activities of daily living, housekeeping, laundry, and medication management. R1's IAPP dated March 8, 2023, lacked statements of specific measures to be taken to minimize the risk of R1's identified vulnerabilities. On June 21, 2023, at 11:45 a.m., owner (OWN)-A stated she was unaware R1's IAPP was incomplete and would update the document to meet requirements. The licensee's undated policy titled Abuse Prevention plan indicated interventions to address areas of concern would be documented on each resident's IAPP. No further information was provided.	0 630		

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0 630	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas including posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. In addition, there was no evidence of the contact information or reporting number for the Minnesota Adult Abuse Reporting Center (MAARC). 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, but was not likely to cause serious injury, impairment, or death), and	0 640		

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0 640	Continued From page 15 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). Findings include: During a facility tour on June 20, 2023, at 10:30 a.m., the resident common areas did not have the required postings for 911 emergency number near the telephones provided by the licensee or anywhere in the common area. On June 21, 2023, at 1:00 p.m., owner (OWN)-A said this required information was not posted. The licensee's emergency policies did not address required postings for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 640		
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	0 660		

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0 660	Continued From page 16 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 interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a facility tuberculosis (TB) risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: A review of documents provided by the licensee revealed that no TB risk assessment was completed for the facility. During an interview on June 20, 2023, at 9:30 a.m., owner (OWN)-A, said a facility TB risk assessment was not completed. The licensee's undated policy titled Tuberculosis Prevention and control, indicated the licensee would maintain a current community TB risk assessment.	0 660		

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0 660	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop a written emergency disaster preparedness plan (EPP)	0 680		

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0 680	Continued From page 18 with all the required content and failed to prominently post an emergency preparedness plan. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During the entrance conference on June 20, 2023, at 10:30 a.m., a request was made to view the licensee's emergency disaster preparedness plan. Registered nurse (RN)-B gave the surveyor a binder of EPP policies. The licensee did not have an EPP binder based on the EPP policies and procedures. During a facility tour at 10:30 a.m. there was no observed signage posted or information regarding the licensee's emergency plan in shared areas. The licensee lacked an emergency plan with the following required content: -a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details of staff assignments in the event of a disaster or emergency -a prominently posted emergency disaster plan	0 680		

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0 680	Continued From page 19 -building emergency exit diagrams provided to all residents - development of policies/procedures to address: -a tracking system used to document locations of volunteers in the facility -a system of medical documentation that preserve resident information, protects confidentiality, and secures/maintains availability of records - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies -a communication plan that included the names and contact information of current staff, entities providing services under the emergency agreement, residents' physicians, other facilities, and volunteers -a communication plan that included a method for sharing information from the emergency plan with residents and/or their families/representatives -documentation of exercises to test the EPP at least twice a year, including unannounced staff drills using the EPP On June 21, 2023, at 11:45 a.m., owner (OWN)-A stated she was unaware of the deficiencies of the EPP and would work to correct them. The licensee's undated policy titled Emergency Management indicated the licensee would have in place an identified plan to ensure the safety and well-being of residents and employees during periods of emergency or disaster.	0 680		

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0 680	Continued From page 20 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 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. This deficient condition 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 800		

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0 800	Continued From page 21 On June 20, 2023, between 10:30 a.m. and 11:25 a.m., survey staff toured the facility with the owner (OWN)-A. During the facility tour, survey staff observed the following: 1. The crank mechanisms were sticking and not working properly on the egress windows in all of the resident sleeping rooms, which prevented these windows from opening fully. Egress windows must be maintained in a state of good repair, to allow exiting the building in a safe and efficient manner in the event of an emergency. 2. One side of the bi-fold closet door was off the track in resident bedroom 1, preventing this closet from operating properly. 3. Two wall tiles were missing in the bathroom for resident room 1. 4. In the common-use bathroom on the main floor, one floor tile was missing and there was a hole in the wall across from the bathroom vanity. 5. The discharge pipe for the pressure relief valve on the water heater in the basement did not terminate within 18 inches of the floor. The discharge piping serving a pressure relief valve must provide a safe place of disposal. 6. One electrical outlet was not provided with a cover on the exterior near the front door. Electrical outlets that are not properly covered could expose residents to electrical wiring. 7. An extension cord was being used improperly to provide permanent wiring to an electrical outlet for a security camera on the exterior of the building near the front door. These deficient conditions were verified by OWN-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 810	Continued From page 22	0 810		
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. This MN Requirement is not met as evidenced by:	0 810		

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0 810	Continued From page 23 Based on observation, interview, and record review, the licensee failed to develop fire safety and evacuation plans with required elements; failed to develop the required training frequency for employees and residents on fire safety and evacuation; and failed to complete required employee evacuation drills. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On June 20, 2023, between 10:30 a.m. and 11:25 a.m., survey staff toured the facility with the owner (OWN)-A. During the facility tour, survey staff observed that evacuation maps identifying the location and number of resident sleeping rooms were not posted in the facility. On June 20, 2023, at approximately 11:25 a.m., records were provided for review. Records were reviewed by survey staff on June 20, 2023, between 11:25 a.m. and 11:45 a.m. Record review of available documentation indicated that the licensee had not developed and maintained fire safety and evacuation plans for this facility location. 1. The licensee had not identified the location and number of resident sleeping rooms in the fire safety and evacuation plans.	0 810		

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0 810	Continued From page 24 2. The licensee had not developed plans with employee actions on how to move or evacuate residents in the event of a fire or similar emergency from this facility location. The fire safety for the workplace template plan indicated to use the RACE acronym and included vague instructions for employees. This plan references fire sprinklers, which the facility does not have. The plans did not provide complete actions for employees to take in the event of a fire or similar emergency. 3. The licensee had not developed plans with fire protection procedures necessary for residents from this facility location. 4. The licensee had not developed plans with 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. On June 20, 2023, at approximately 11:55 a.m., OWN-A verified that the fire safety and evacuation plans for the facility lacked these provisions. Record review of the fire safety for the workplace document indicated that employee training on the fire safety plan would be completed upon hire and annually. No employee training records were provided. Documentation was not provided that included language for resident training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. No resident training records were provided. On June 20, 2023, at approximately 11:55 a.m., the OWN-A explained that residents had moved	0 810		

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0 810	Continued From page 25 in three months ago and confirmed that fire safety and evacuation training for employees and residents had not been developed yet and verified this deficient condition. Record review of the available documentation indicated that the facility had not conducted evacuation drills. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On June 20, 2023, at approximately 11:55 a.m., the OWN-A explained that residents had moved in three months ago and confirmed that evacuation drills had not yet been performed and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01620		

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01620	Continued From page 26 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure a comprehensive 14-day reassessment was completed after admission for three of three residents, (R1, R2, and R3) 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). Findings include: R1's diagnoses included bilateral lower extremity weakness and swollen feet. R1 received services including assistance with activities of daily living, meals, housekeeping, laundry, and medication management. R1's medical record indicated the resident started receiving services from the facility on March 9, 2023. R1's medical record lacked evidence of a	01620		

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	38626	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAMAANI ASSISTANT LIVING LLC	1873 STINSON BOULEVARD NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 27 14-day post-admission reassessment completed by the facility registered nurse (RN). R2's diagnoses included asthma, chronic obstructive pulmonary disease, depression, and bipolar disorder. R2 received services including assistance with activities of daily living, meals, housekeeping, laundry, and medication management. R2's medical record indicated the resident started receiving services from the facility on March 21, 2023. R2's medical record lacked evidence of a 14-day post-admission reassessment completed by the facility registered nurse (RN). R3's diagnoses included bipolar disorder, anxiety, and depression. R3 received services including assistance with meals, housekeeping, laundry, and medication management. R3's medical record indicated the resident started receiving services from the facility on April 12, 2023. R3's medical record lacked evidence of a 14-day post-admission reassessment completed by the facility registered nurse (RN). On June 21, 2023, at 11:45 a.m., owner (OWN)-A and registered nurse (RN)-B stated they were unaware the required assessments had not been completed and would add the 14-day assessment to the admission process. The licensee's undated policy titled Comprehensive Resident Assessment indicated resident assessment and monitoring must be conducted no more than 14 days after initiation of	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38626	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAMAANI ASSISTANT LIVING LLC	1873 STINSON BOULEVARD NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 28 services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38626	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAMAANI ASSISTANT LIVING LLC	1873 STINSON BOULEVARD NEW BRIGHTON, MN 55112

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01650	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for three of three residents (R1, R2, and R3) 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 the potential to affect a large portion or all of the residents). Findings include: R1's diagnoses included bilateral lower extremity weakness and swollen feet. R1 received services including assistance with activities of daily living, meals, housekeeping, laundry, and medication management. R2's diagnoses included asthma, chronic obstructive pulmonary disease, depression, and bipolar disorder. R2 received services including assistance with activities of daily living, meals, housekeeping, laundry, and medication management. R3's diagnoses included bipolar disorder, anxiety, and depression. R3 received services including assistance with meals, housekeeping, laundry, and medication	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38626	A. BUILDING: _____ B. WING _____	06/21/2023

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01650	Continued From page 30 management. R1, R2, and R3's service plans lacked the following content: -a description of all the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services. On June 21, 2023, at 11:45 a.m., owner (OWN)-A and registered nurse (RN)-B stated they were unaware the service plans lacked required content and would correct the service plans for the licensee's current residents. The licensee's undated policy titled, Service Plan, indicated all required content was to be included in the service plans per 144G.70 subd. 4 statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01650		

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

Type: Full
Date: *06/20/23*
Time: 13:17:05
Report: 8058231135

Food and Beverage Establishment Inspection Report

Location:
Shamaani Assistant Living LLC
1873 Stinson Boulevard
New Brighton, MN55112
Ramsey County, 62

Establishment Info:
ID #: 0041336
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12DMN

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

DISCUSSED APPLICATION PROCESS FOR SERVE SAFE TO CFPM

Comply By: 07/28/23

Food and Equipment Temperatures

Process/Item: STRAWBERRY
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR: MAERIN RENEE
ESTABLISHMENT REP: KHADIIJA ALI

RESIDENTIAL HOME IN RESIDENTIAL NEIGHBORHOOD, NON-COMMERCIAL MATERIALS AND EQUIPMENT

FINISHES ARE PLASTER, LAMINATE, VINYL, WOOD.

Type: Full
Date: *06/20/23*
Time: 13:17:05
Report: 8058231135
Shamaani Assistant Living LLC

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058231135 of 06/20/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
K. ALI

Signed:_____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us