



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

April 17, 2025

Licensee

Tamay Home Healthcare LLC
5824 42nd Avenue North
Crystal, MN 55422

RE: Initial(remove if not initial) License Number 411884
Health Facility Identification Number (HFID) 39918
Project Number(s) SL39918015

Dear Licensee:

On April 14, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed October 24, 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 April 17, 2025.

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.

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.

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,

A handwritten signature in black ink that reads 'Rick Michals'.

Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

January 31, 2025

Licensee

Tamay Home Healthcare LLC
5824 42nd Avenue North
Crystal, MN 55422

RE: Provisional Conditional License Number 411884
Health Facility Identification Number (HFID) 39918
Project Number(s) SL39918015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 24, 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.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **May 1, 2025**.

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 provisional 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.

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Tamay Home Healthcare LLC a conditional provisional 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 Tamay Home Healthcare LLC is in substantial compliance.

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

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.
- b. **No new admissions:** Tamay Home Healthcare LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Tamay Home Healthcare LLC must provide the Department:
 - i. A list of the names and birthdates of any individuals Tamay Home Healthcare LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents including:
 1. Name and birthdate of each resident
 2. Current payment source for services
 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager

4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

- c. **Consultant:** Tamay Home Healthcare LLC will contract with an RN to provide consultation concerning all resident(s) to whom Tamay Home Healthcare LLC provides provisional licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Tamay Home Healthcare LLC. 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 Tamay Home Healthcare LLC and MDH must review the RN's credentials and approve the selection. Tamay Home Healthcare LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Tamay Home Healthcare LLC in an effort to help Tamay Home Healthcare LLC 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. Tamay Home Healthcare LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Tamay Home Healthcare LLC and the RN consultant about a change. Each report will be electronically submitted to: Brandon Mueller, State Evaluation Team, Health Regulation Division, at brandon.w.mueller@state.mn.us and can be reached at 651-247-2064 (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 Tamay Home Healthcare LLC to correct the violations cited during the survey as well as to determine the overall practice of Tamay Home Healthcare LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** Tamay Home Healthcare LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if Tamay Home Healthcare LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Tamay Home Healthcare LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Tamay Home Healthcare LLC. If MDH determines Tamay Home Healthcare LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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 state form with your organization's Governing Body.

If you have any questions, please contact Casey DeVries directly at: 651-201-5917.

Sincerely,

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

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39918015-0 On October 21, 2024, through October 24, 2024, the Minnesota Department of Health conducted an initial survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs twenty-four hours a day, seven days a week. 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: R1	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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	
0 460	Continued From page 2 R1 was admitted to the licensee and began receiving assisted living services on February 29, 2024. R2 R2 was admitted to the licensee and began receiving assisted living services on May 28, 2024. R3 R3 was admitted to the licensee and began receiving assisted living services on August 23, 2024. On October 21, 2024, at 11:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated the residents had call buttons in each of their rooms to summon staff when needed. On October 22, 2024, at 12:20 p.m., the surveyor observed R3's room and did not see a call button or other means to summon staff. R3 stated when they needed something they went out to the facility common areas and found staff. On October 24, 2024, at 2:54 p.m., the surveyor requested that CNS-A show them the call buttons in the resident rooms. CNS-A stated they did not have call buttons in any resident rooms. CNS-A stated they thought they had gotten call buttons but forgot to order them. CNS-A stated they planned to order and install the call buttons as soon as possible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 470	Continued From page 3	0 470			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a 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	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 470	Continued From page 4 year. In addition, the licensee failed to post their daily staffing schedule in a central location accessible to staff, residents, volunteers, and the public. 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: STAFFING PLAN On October 21, 2024, at 1:30 p.m., CNS-A presented the surveyor with a Survey Binder that included a staffing plan that had another licensee listed as the provider and was dated October 2022. On October 21, 2024, at 4:11 p.m., the surveyor requested the staffing plan for licensee from assisted living director (ALD)-C. The surveyor showed ALD-C the staffing plan that had been provided with the name of another licensee listed. ALD-C stated they knew they had completed one and would find it. On October 21, 2024, at 4:36 p.m., CNS-A presented the surveyor with a staffing plan with licensee's name at the top of the plan, dated January 1, 2024, and was signed by ALD-C on June 1, 2024. The staffing plan lacked inclusion of CNS-A's signature. On October 21, 2024, at 4:36 p.m., CNS-A stated	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 470	Continued From page 5 they had not developed, reviewed, or provided any feedback on the staffing plan. CNS-A stated some of the information in the staffing plan was not accurate for the licensee and would need to be updated. CNS-A stated the bed capacity was listed as three and theirs was five. STAFFING SCHEDULE On October 21, 2024, at 1:32 p.m., during the facility tour, the surveyor observed there was not a daily schedule posted anywhere in the facility. On October 21, 2024, at 1:32 p.m., ALD-C stated they had planned on putting up a bulletin board by the main entrance with all the required information for the residents but had not done that yet. On October 22, 2024, at 9:30 a.m., the surveyor observed a large bulletin board had been hung up near the main entrance of the facility. The bulletin board included a document titled Biweekly Schedule October 2024. The schedule indicated the ULP that was scheduled each day from 7:00 a.m. to 7:00 p.m., and 7:00 p.m. to 7:00 a.m. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 480	Continued From page 6 capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 7 breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the documents titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 21, 2024, and October 23, 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	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 550	Continued From page 8 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 required information related to the grievance procedure. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 21, 2024, at 1:32 p.m., during a facility tour, the surveyor observed the common	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 550	Continued From page 9 areas of the facility lacked the required posting of the grievance procedure. On October 21, 2024, at 1:32 p.m., assisted living director (ALD)-C stated they had planned on putting up a bulletin board by the main entrance that would include the grievance procedure but had not done that yet. On October 22, 2024, at 9:30 a.m., the surveyor observed a large bulletin board had been hung up near the main entrance of the facility. The bulletin board included licensee's Complaint/ Grievance policy, Grievance/ Complaint procedure, and blank Complaint Forms. The posted documents included the following information: - grievance procedure; - the name, telephone number, and email contact information for the individuals responsible for handling resident grievances; - contact information for the Office of Ombudsman for Long-Term Care; - contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; and - a telephone number the Minnesota Adult Abuse Reporting Center. The notice lacked the following required statement, "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". The licensee's Complaint/ Grievance policy, dated August 1, 2023, indicated work to resolve complaints would be timely and appropriate for employee or resident concerns. The policy did not include information related to grievances that is	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 550	Continued From page 10 required to be conspicuously posted. No further information was provided. 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 any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility. This had the potential to affect all residents, staff, and visitors. 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 the residents). The findings include: On October 21, 2024, at 11:30 a.m., upon entering the facility, the surveyor observed the assisted living license was not posted at the facility's main entrance. On October 21, 2024, at 1:32 p.m., assisted living	0 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
0 570	Continued From page 11 director (ALD)-C stated they had planned on putting up a bulletin board by the main entrance with all the required information but had not done that yet. On October 22, 2024, at 9:30 a.m., the surveyor observed a large bulletin board had been hung up near the main entrance of the facility. The bulletin board included licensee's original current assisted living license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
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 ensure an individual abuse prevention plan was developed to include the required content for two of three residents (R1, R3).	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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 12 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: R1 R1 was admitted to the licensee and began receiving assisted living services on February 29, 2024. R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia. R1's Service Plan/ Addendum to Contract-Waiver, dated July 17, 2024, indicated R1 received medication administration, assistance with dressing, grooming, bathing, housekeeping, laundry, and socialization. R1's Individual Abuse Prevention Plan, dated July 31, 2024, indicated R1 was at risk to be abused by others and included interventions for prevention of abuse from others. R1's record lacked an individual abuse prevention plan (IAPP) to include: - risk of abusing other vulnerable adults. R3 R3 was admitted to the licensee and began receiving assisted living services on August 23, 2024.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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 R3's diagnoses included bipolar depressive disorder. R3's Service Plan/ Addendum to Contract-Waiver, dated August 23, 2024, indicated R3 received medication set up, assistance with dressing, grooming, bathing, housekeeping, laundry, behavior management, safety checks, and socialization. R3's Individual Abuse Prevention Plan, dated September 5, 2024, indicated R3 was at risk of being abused by others and included interventions for prevention of abuse from others. R3's record lacked an individual abuse prevention plan (IAPP) to include: - risk of abusing other vulnerable adults. On October 24, 2024, at 4:30 p.m., clinical nurse supervisor (CNS)-A stated they completed the individual abuse prevention plan on admission, with reassessments, and if there were changes to a resident's vulnerability. CNS-A stated they thought they included all the required components in their assessment documentation. CNS-A reviewed R1's Individual Abuse Prevention Plan and verified the question for risk of abuse to other individuals was not present on the assessment. The licensee's undated Abuse Prevention Plan policy indicated all residents would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The policy indicated licensee would develop a statement of the specific measures that would be taken to minimize the risk of abuse to that person and other vulnerable adults.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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 14 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 the 911 emergency phone number near the facility house phone. This had the potential to affect all residents, staff, and visitors 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) 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).	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
0 640	Continued From page 15 The findings include: On October 21, 2024, at 1:32 p.m., during a facility tour, the surveyor observed a land line telephone on a desk in an open common area of the facility lower level. The room the telephone was in lacked a 911 posting required to be near all facility telephones. On October 22, 2024, at 2:25 p.m., R3 came into the dining room area the surveyor was working from and stated they were looking for the facility cordless telephone. R3 stated the telephone was usually kept on the table by the wall. Unlicensed personnel (ULP)-D stated the cordless telephone was kept on the table for residents to use upstairs. The room lacked a 911 posting required to be near all facility telephones. On October 24, 2024, at 4:30 p.m., assisted living director (ALD)-C stated they did not realize 911 postings were a requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, 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	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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 16 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content of training and competency for continuous glucose monitoring for two of two employees (unlicensed personnel (ULP)-B, ULP-D) and competency of vital sign monitoring (blood pressure, temperature, pulse, and respirations) for one of two employees (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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 17 TRAINING AND COMPETENCY FOR CONTNUOUS GLUCOSE MONITOR ULP-B ULP-B had a hire date of March 3, 2024, ULP-B provided direct services to residents. ULP-D ULP-D had a hire date of August 16, 2024, ULP-D provided direct services to residents. On October 22, 2024, at 11:20 a.m., the surveyor observed ULP-D check R1's blood glucose level using continuous glucose monitoring. ULP-D scanned the sensor on R1's arm with a specific mobile device and reported a result of 171. ULP-B and ULP-D's employee records lacked documentation of required competency training completed by a registered nurse (RN) for monitoring blood glucose using a continuous blood glucose monitor. On October 22, 2024, at 4:36 p.m., ULP-D stated they received training on how to use the continuous glucose monitoring system from CNS-A. ULP-D stated they watched videos demonstrating the procedure then learned the procedure from CNS-A, observed CNS-A perform the task, and then CNS-A observed ULP-D check R1's blood glucose level using the continuous blood glucose monitor. On October 22, 2024, at 10:40 a.m., CNS-A stated R1 had used the continuous glucose monitor since they moved into the facility on February 29, 2024. CNS-A stated they did train each ULP on the continuous glucose monitor during new employee orientation but did not have a document for competency because they thought it was included on the other blood	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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 18 glucose competency form they used. CNS-A stated they showed the monitor and sensor to each employee, demonstrated how to scan the sensor with the monitor, and had the employee demonstrate back by scanning for a blood glucose result on R1's arm sensor that had been placed by the RN. TRAINING AND COMPETENCY FOR VITAL SIGNS ULP-D ULP-D had a hire date of August 16, 2024, ULP-D provided direct services to residents. On October 22, 2024, at 3:36 p.m., the surveyor observed ULP-D prepare and administer medications for R1. ULP-D's employee record included competency evaluations for medication administration and checking oxygen saturation levels, however, lacked documentation of required competency training completed by a registered nurse (RN) for monitoring blood pressure, temperature, pulse, and respirations. On October 22, 2024, at 4:36 p.m., ULP-D stated they were trained by CNS-A on vital signs including blood pressure, temperature, pulse, respirations, and oxygen saturation. On October 23, 2024, at 1:30 p.m., CNS-A stated they provided in person hands on training for ULP-D with checking blood pressure, temperature, pulse, respirations, and oxygen saturation during the same training session. CNS-A stated they must have not completed all the required documents, or they might have been misfiled.	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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 19 The licensee's undated Employee Records policy indicated each employee would have a record that would include records of orientation and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the provisional 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 potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - reviewed missing resident plan quarterly; - policy and procedure for alternate sources of energy to maintain temperatures to protect resident health/safety, safe/sanitary storage of provisions, emergency lighting, fire detection, extinguishing, alarm systems, and sewage and waste disposal; - written communication plan that included names and contact information of staff, entities providing services under agreement, residents' physicians, other facilities, and local emergency agencies for the city of Robbinsdale; - written training and testing program of EPP; - EPP training at least annually for all staff; and - conducted exercises to test the EPP at least twice per year.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 21 On October 23, 2024, at 9:30 a.m., CNS-A stated they had reviewed the missing resident policy one time since the facility opened in February 2024, but did not know it was required to be reviewed quarterly and did not have documentation that it was reviewed. On October 24, 2024, at 4:30 p.m., assisted living director (ALD)-C stated they would update the EPP to include any missing information. The licensee's undated Emergency Management policy indicated licensee would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or disaster that disrupted facility services. The licensee's undated Missing Resident policy indicated all staff were trained and made aware of the missing resident procedure upon orientation. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor would 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			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
0 730	Continued From page 22 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
0 730	Continued From page 23 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain resident records with all required content related to health information including communication of pertinent resident information and reports made to the registered nurse (RN), documentation of medication and treatment administration; and documentation that services had been provided as identified in the service plan for three of three residents (R1, R2, R3). 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: CURRENT RESIDENTS R1 R1 was admitted to the licensee and began receiving assisted living services on February 29, 2024. R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia.	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
0 730	Continued From page 24 R1's Service Plan/ Addendum to Contract-Waiver, dated July 17, 2024, indicated R1 received medication administration, assistance with dressing, grooming, bathing, housekeeping, laundry, and socialization. R2 R2 was admitted to the licensee and began receiving assisted living services on May 28, 2024. R2's diagnoses included hypertension, hereditary and idiopathic neuropathy. R2's Service Plan/ Addendum to Contract-Waiver, dated May 28, 2024, indicated R2 received medication administration, assistance with dressing, grooming, bathing, housekeeping, shopping, and socialization. R3 R3 was admitted to the licensee and began receiving assisted living services on August 23, 2024. R3's diagnoses included bipolar depressive disorder. R3's Service Plan/ Addendum to Contract-Waiver, dated August 23, 2024, indicated R3 received medication set up, assistance with dressing, grooming, bathing, housekeeping, laundry, behavior management, safety checks, and socialization. STAFF NOTIFICATIONS TO THE RN On October 21, 2024, at 11:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated resident records were electronic	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
0 730	Continued From page 25 and paper format. CNS-A stated nursing used an electronic medical record (EMR) for documentation and unlicensed personnel (ULP) documented on paper. CNS-A stated they would eventually train all staff and have them start using the EMR for documentation but had not done that yet. CNS-A stated staff contacted the on-call RN by phone call or text. On October 22, 2024, at 2:16 p.m., the surveyor observed resources utilized by ULPs for daily documentation. There was a binder that contained the current medication administration record (MAR) kept in the medication file cabinet. Also, in the medication file cabinet there was a notebook for R1's blood glucose results. Kept in a drawer in the kitchen, there was a binder with Service Recap Summaries for ULPs to document services provided for each resident. The surveyor observed the documentation resources to be checklist format without space to document details that occurred outside of the options on the checklists or boxes to initial. On October 22, 2024, at 2:16, ULP-D stated they did not document notes related to resident care. ULP-D stated they did notify the RN when things occurred outside of the normal routine but there was no place to document the details of what occurred or that they had notified the RN. On October 24, 2024, at 2:28 p.m., CNS-A stated they were on call twenty-four hours per day seven days a week and did receive calls and text messages from ULPs with questions about care or medications, and reports of abnormal symptoms. CNS-A stated they advised ULPs over the phone and came into the facility as needed based on their assessment of information during the call. CNS-A stated they only documented	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
0 730	Continued From page 26 when they had a planned visit to the facility. CNS-A stated they did not document when they received a call from the ULP about resident status, as needed medications, or other questions. CNS-A stated they were working on improvements to the documentation system. RECORDS OF MEDICATION ADMINISTRATION, TREATMENTS, AND SERVICES PROVIDED On October 22, 2024, at 3:00 p.m., the surveyor requested to review previous months of MARs for R1 and R2, blood glucose records for R1, and service recap summaries for R1, R2, and R3. On October 22, 2024, at 3:45 p.m., CNS-A brought the surveyor other documents they had requested to review. CNS-A stated they were looking for the previous MARs, glucose records, and service recap summaries but had not been able to locate them. On October 22, 2024, at 4:22 p.m., CNS-A pointed to the file cabinet in the lower level of the facility and stated the "papers are all mixed up" and they had not been able to locate the requested documents but were still looking. On October 23, 2024, at 9:30 a.m., CNS-A stated they had not been able to locate any of the requested MARs, glucose records, or service recap summaries for any resident. CNS-A stated all documents were maintained at the facility with no offsite storage and they did not know what happened to them. On October 24, 2024, at 3:30 p.m., the surveyor observed the binder containing service recap summaries to include additional documents than	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
0 730	Continued From page 27 when previously viewed. The binder included the following Service Recap Summary records for each resident: R1 August, September, and October 2024; R2 August, September, and October 2024; and R3 August, September, and October 2024. On October 24, 2024, at 4:30 p.m., CNS-A stated they had located some of the service recap summary documents and put them in the binder but had not located any of the past MARs or blood glucose records. The resident records lacked the following documents: R1 lacked MARs from February, March, April, May, June, July, and September 2024; R1 lacked Service Recap Summaries from February, March, April, May, June, and July 2024; R1 lacked record of blood glucose results from February, March, April, May, June, July, August, and September 2024; R2 lacked MARs from May, June, July, and September 2024; and R2 lacked Service Recap Summaries from May, June, and July 2024. The licensee's undated Resident Records policy indicated a resident record was a legal document that would be maintained for each person receiving assisted living services. The licensee would retain a resident's record for at least five years following a resident's discharge or termination of services. Contents of the resident record included the following information: - current and previous assessments and service plans; - all records of communications pertinent to the resident's services;	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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	
0 730	Continued From page 28 - documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; - documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; - documentation that services have been provided as identified in the service plan; and - other documentation required under this license and relevant to the resident's services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
0 780	Continued From page 29 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During facility tour on October 22, 2024, from 12:10 p.m., through 12:44 p.m. with clinical nurse supervisor (CNS)-A, the surveyor observed that the smoke alarm inside sleeping room 103 and 104, located in the basement, were not interconnected with other alarms throughout the facility so activation of one alarm activates all alarms in the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
0 780	Continued From page 30 alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour CNS-A tested the smoke alarms and verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. CNS-A stated they understood the requirement for interconnected smoke alarms. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required for the facility. 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	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
0 790	Continued From page 31 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on October 22, 2024, from 12:10 p.m., through 12:44 p.m. with clinical nurse supervisor (CNS)-A, the surveyor observed that the portable fire extinguishers mounted in the kitchen on the main floor and in the basement near the bottom of the stairs lacked records to show annual testing and certification was performed. Both extinguishers had a 2022 date stamp on the bottom of the extinguisher. The extinguisher in the kitchen was mounted with the top of the extinguisher 69 inches above the floor. The surveyor explained to CNS-A, that portable fire extinguishers are required to be annually replaced with a new extinguisher or serviced annually by a certified technician. The surveyor explained that extinguishers are to be mounted with the top of the extinguisher not more than 60 inches above the floor. During the tour, CNS-A, verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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,	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 32 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 facility tour on October 22, 2024, from 12:10 p.m., through 12:44 p.m. with clinical nurse supervisor (CNS)-A, the surveyor observed the following: There was a sliding door in the kitchen that led to the exterior. The door was more than six feet above the ground and there was no deck or landing in place to step on outside the door. There was a metal guard on the exterior side of the door, but the bottom of the guard was loose	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 33 and not fastened in place. Guardrails are essential and must be maintained to avoid falls and injury. During the tour CNS-A directed staff to fasten a wood block at the bottom the door to prevent it from being opened. The dryer vent was disconnected from the dryer and there was lint behind and around the dryer. Dryer vents must be properly connected to discharge heat and lint to the exterior and not create a fire hazard. CNS-A verified the dryer vent was disconnected and stated they would have connected before using the dryer. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff of assisted living facilities shall receive	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 34 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on October 22, 2024, from 12:10 p.m., through 12:44 p.m. with clinical nurse supervisor (CNS)-A, the surveyor observed that	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 35 the evacuation map posted in the basement of the facility showed the floor plan and evacuation routes of the facility's main floor. The posted evacuation maps did not show the location and number of resident sleeping rooms. On October 22, 2024, at 12:46 p.m., clinical nurse supervisor (CNS)-A, provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Internal", undated, failed to provide the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke doors. The policies had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at this licensed facility which did not have life safety systems stated in the policy. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on October 22, 2024, at 1:06 p.m., CNS-A stated they understood the areas of	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 36 the policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
0 920	Continued From page 37 the required content for three of three residents (R1, R2, R3). 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: R1's Resident Contract for Assisted Living was signed by R1 and assisted living director (ALD)-C on February 19, 2024. R2's Resident Contract for Assisted Living was signed by R2 and clinical nurse supervisor (CNS)-A on May 29, 2024. R3's Resident Contract for Assisted Living was signed by R3, R3's legal representative, and ALD-C on August 21, 2024. The documents signed by R1, R2, and R3 were the same fourteen-page contract version. R1, R2, and R3's Resident Contract for Assisted Living lacked documentation of: - a disclosure of the category of assisted living facility license held by the facility; - if the facility was not an assisted living facility with dementia care, a disclosure that it did not hold an assisted living with dementia care license; and - disclosure of the facility's ability to provide specialized diets.	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
0 920	Continued From page 38 On October 24, 2024, at 4:30 p.m., ALD-C reviewed the Resident Contract for Assisted Living and was not able to locate the items listed. ALD-C stated they thought the contract included all items required. The licensee's undated Assisted Living Contracts policy indicated the licensee would establish a contract with each resident at the time of admission to clarify the required contract elements for compliance with the statute. The policy indicated items that must be included in the contract and listed disclosure of the facility's ability to provide specialized diets. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 39 (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 current service plan included a signature or other authentication by the licensee and resident or resident's representative to document agreement of services to be provided for one of three residents (R1). In addition, the licensee failed to execute a signed service plan to include an accurate account of services being provided by the licensee for three of three residents (R1, R2, R3). 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 and began receiving assisted living services on February 29, 2024. R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia. R1's Service Plan/ Addendum to Contract-	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 40 Waiver, dated July 17, 2024, indicated R1 received the following services: - medication administration seven times per day; - medication setup by the registered nurse (RN) one day per week; - assistance with dressing twice daily; - assistance with grooming daily; - bathing assistance with shower or bath one day per week; - assistance with ambulation three times per day; - meal assistance three times daily; - appointment reminders and assistance daily; - transportation daily; - activity assistance twice daily; - socialization twice daily; - finance management one day per week; - shopping one day per week; - symptom management of depression and wandering three times daily; - daily light housekeeping and heavy housekeeping one day per week; - removal of garbage three times per day; - laundry two days per week; - linen change one day per week; and - safety check four times per day. SERVICES ADDED BUT NOT AUTHENTICATED R1's Service Recap Summary dated October 2024, indicated R2 received the following services which were not included on R2's service plan: - recording blood glucose at 8:00 a.m., daily. R1's Blood Glucose Record notebook indicated staff were checking R1's blood glucose level twice daily in the a.m. and p.m. On October 24, 2024, at 5:26 p.m., the notebook included the twice daily blood glucose levels and staff initials for October 1 through the morning of October 24, 2024.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 41 On October 21, 2024, at 5:02 p.m., clinical nurse supervisor (CNS)-A stated R1 used a continuous glucose monitor (CGM) and they changed the sensor in R1's arm every fourteen days. CNS-A stated staff checked R1's blood glucose level twice daily and additional times when R1 complained of any symptoms. CNS-A stated R1 had CGM since they moved into the facility. CNS-A stated they thought they had added blood glucose monitoring to R1's service plan. R1's Service Plan/ Addendum to Contract-Waiver, dated October 22, 2024, included services previously authenticated on the July 17, 2024, service plan. In addition, recording blood glucose twice daily and RN supervision of blood glucose recording one day per week had been added to the service plan. The date of the additions was not specified and had not been authenticated by signature of R1 or licensee. SERVICES PROVIDED NOT INCLUDED ON SERVICE PLAN R1's Clinical Update Assessment, dated October 12, 2024, indicated R1 had special dressing needs of assistance with compression stockings on and off. On October 22, 2024, at 12:01 p.m., unlicensed personnel (ULP)-D stated they assisted R1 with showers daily. ULP-D stated cleanliness was important to R1, and they wanted to shower every day. ULP-D stated they assisted with putting on compression stockings in the morning, removing them at night, washing them in the washing machine, and hanging them up to dry. On October 23, 2024, at 11:45 a.m., CNS-A reviewed the signed service plan and stated the	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 42 service plan should include additional services the licensee was providing of assistance with compression stockings daily, checking R1's weight weekly, and providing snacks twice daily. CNS-A stated they had put showering on the service plan as once weekly because that was what R1's payer allowed. They assisted R1 daily, but reimbursement only occurred for one of those days. CNS-A stated the service plan should direct what the staff are doing which would be assisting R1 with showering daily. SERVICE NOT PROVIDED BUT INCLUDED ON SERVICE PLAN R1 On October 22, 2024, at 1:57 p.m., the surveyor observed the medication storage area. R1's drawer contained oral medications that were in prescription bottles. There were two one-week medication boxes that were both empty. On October 22, 2024, at 3:29 p.m., the surveyor observed ULP-D prepare and administer medications for R1. ULP-D removed the following medications from the prescription bottles in R1's drawer: -amlodipine 5 milligrams (mg) and - tamulosin hydrochloride (hcl) 0.4 mg. ULP-D put each medication into a plastic cup and brought the cup to R1. R1 swallowed the medications with water. On October 23, 2024, at 9:30 a.m., CNS-A verified weekly medication setup by the RN was not a service R1 had received. R2 R2 was admitted to the licensee and began receiving assisted living services on May 28, 2024.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 43 R2's diagnoses included hypertension, hereditary and idiopathic neuropathy. R2's Service Plan/ Addendum to Contract-Waiver, dated May 28, 2024, indicated R2 received the following services: - medication administration two times per day; - medication setup by the RN one day per week; - assistance with dressing twice daily; - assistance with grooming daily; - bathing assistance with shower or bath one day per week; - assistance with ambulation three times per day; - meal assistance three times daily; - appointment reminders and assistance daily; - transportation daily; - activity assistance twice daily; - socialization twice daily; - finance management one day per week; - shopping one day per week; - symptom management of depression three times daily; - daily light housekeeping and heavy housekeeping one day per week; - removal of garbage three times per day; - laundry three days per week; - linen change one day per week; and - safety check four times per day. On October 22, 2024, at 1:57 p.m., the surveyor observed the medication storage area. R2's drawer contained three medication bottles and small plastic cups used to set up individual doses of medications. On October 23, 204, at 9:30 a.m., CNS-A stated weekly medication setup by the RN was not a service R2 had received.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 44 R3 R3 was admitted to the licensee and began receiving assisted living services on August 23, 2024. R3's diagnoses included bipolar depressive disorder. R3's Service Plan/ Addendum to Contract-Waiver, dated August 23, 2024, indicated R3 received the following services: - medication setup by the RN one day per week; - assistance with dressing twice daily; - assistance with grooming daily; - bathing assistance with shower or bath every two days; - meal assistance three times daily; - appointment reminders and assistance daily; - transportation daily; - socialization twice daily; - finance management one day per week; - shopping one day per week; - symptom management of depression, anxiety, agitation, repetition, self-injury, and wandering three times daily; - daily light housekeeping and heavy housekeeping one day per week; - removal of garbage three times per day; - laundry two days per week; - linen change one day per week; and - safety check four times per day. On October 21, 2024, at 11:40 a.m., during the entrance conference, CNS-A stated licensee did not assist R3 with any medications. CNS-A stated R3 did not have any medications or orders at this time. On October 23, 2024, at 9:30 a.m., CNS-A stated they had included medication set up on R3's	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 45 service plan because they believed R3 would initiate care with a new provider and start taking medications but that had not happened yet. CNS-A verified weekly medication setup by the RN was not a service R3 had received. On October 21, 2024, at 11:40 a.m., during the entrance conference, CNS-A stated the assessment generated interventions and tasks to the service plan. CNS-A stated they and assisted living director (ALD)-C collaborated to ensure the service plan was accurate with the services being provided for each resident. The licensee's undated Service Plan policy indicated assisted living services would be provided according to the current written service plan. The service plan would be based on nursing assessment, resident needs, preferences, and accepted standards of practice for professional nursing or other relevant standards. All services provided would be agreed upon and included on the service plan. The service plan and any revisions would include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. The service plan would be revised as needed based on resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01700	Continued From page 46 management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment, prior to providing medication management services, to include all required content for two of two residents who received medication management services (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 47 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 21, 2024, at 11:40 a.m., CNS-A stated a medication assessment was completed on admission for each new resident. The medication assessment and plan were reviewed at each ongoing reassessment. ORDERS AND DOCUMENTATION R1 R1 was admitted to the licensee and began receiving assisted living services on February 29, 2024. R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia. R1's Service Plan/ Addendum to Contract-Waiver, dated July 17, 2024, indicated R1 received medication administration, assistance with dressing, grooming, bathing, housekeeping, laundry, and socialization. On October 22, 2024, at 3:36 p.m., the surveyor observed unlicensed personnel (ULP)-D prepare and administer medications for R1. R1's record included a document titled Summary of Today's Visit, dated August 14, 2024, that was manually signed by R1's physician. On October 23, 2024, at 11:45 a.m., CNS-A stated the signed Summary of Today's Visit document was the	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 48 provider orders. On October 23, 2024, at 1:45 p.m., the surveyor asked what licensee was using for R1's orders prior to August 14, 2024, CNS-A stated they were using an After Visit Summary (AVS) R1 brought with them on admission. The record included a document titled, Your Medication List, dated January 8, 2024. The document indicated it was page three of three. Pages one and two were not included in the record. The document included R1's name and a medical record number but lacked information of what physician the list came from and did not include a manual or electronic signature. CNS-A verified that was the document used as R1's orders. On October 22, 2024, at 3:00 p.m., the surveyor requested R1's Medication Administration Records (MAR) from admission to current. On October 22, 2024, at 4:22 p.m., clinical nurse supervisor (CNS)-A pointed to the file cabinet in the lower level of the facility and stated the "papers are all mixed up" and they had not been able to locate past MARs for any resident. Only MARs for the current month of October and August 2024 were presented during the course of the survey. R1 RESPIRATORY SYMPTOMS On October 21, 2024, at 1:07 p.m., ULP-D called 911 in response to symptoms of chest pain and trouble breathing expressed by R1. R1 was transported to a hospital via ambulance with ULP-B accompanying them and ULP-D remained at the facility. ULP-B later reported that the ambulance personnel administered medications via nebulizer to R1. R1 was seen in the emergency department but not hospitalized and	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 49 returned to the facility the evening of October 21, 2024. R1's AVS, dated October 21, 2024, indicated normal electrocardiogram and chest x-rays with no medication changes or new diagnosis. On October 22, 2024, at 10:50 a.m., R1, R2, and ULP-D went for a walk outside. They returned to the facility at 11:20 a.m. R1 stated they felt tired and short of breath. R1 walked into the facility and up one flight of stairs to their room. R1 stopped at their room door in the kitchen and leaned against the doorframe to rest. The surveyor observed R1 leaning against the doorframe taking deep breaths with eyes closed for approximately one minute before they proceeded to walk into their room. On October 22, 2024, at 12:01 p.m., ULP-D stated R1 sometimes used an inhaler when they had shortness of breath but had not wanted to use the inhaler today. R1 ORDER DISCREPENCIES R1's document Your Medication List, dated January 8, 2024, included the following medications: - Advair Diskus 250-50 microgram (mcg) per actuation (act) inhaler one puff by mouth twice daily; - Paxlovid (300/100 therapy pack) two capsules of 150 milligram (mg) and one capsule of 100 mg by mouth two times daily; - ketotifen fumarate 0.035% ophthalmic solution one drop into affected eye twice daily; - Xarelto 20 mg one tablet with food by mouth once daily; - amlodipine 5 mg one tablet by mouth daily at 2:00 p.m.;	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 50 - atorvastatin 40 mg one tablet by mouth once daily; - loratadine 10 mg one tablet by mouth once daily; - losartan 100 mg one tablet by mouth once daily; - metformin 500 mg one tablet by mouth with meals twice daily; - metoprolol tartrate 25 mg one tablet by mouth twice daily with food; - omeprazole 20 mg one capsule thirty minutes before morning meal once daily; - tamsulosin 0.4 mg one capsule; - albuterol 108 mcg/ act inhaler two puffs as needed by inhalation every six hours; - olopatadine 0.1% ophthalmic solution one drop into both eyes two times daily; and - bacitracin 500 units per gram external ointment applied topically two times daily. R1's Summary of Today's Visit, dated August 14, 2024, and manually signed by R1's physician indicated the following medications and equipment to be currently ordered for R1: - Advair Diskus 250-50 mcg per act one puff via inhalation twice daily. - Paxlovid (300/100 therapy pack) two capsules of 150 mg and one capsule of 100 mg taken together by mouth two times daily; - nebulizer to use for duoneb; - albuterol sulfate 2.5 mg per 3 milliliters (ml) 0.083% 3 ml inhalation every 4 hours; - prednisone 20 mg one tablet by mouth once daily for five days with asthma flare; - robafen DM cough syrup 100 mg per 5 ml take 10 ml as needed every four hours; - Tussin DM 10 mg per 5 ml take ten ml as needed by mouth every four hours; - Ketotifen fumarate 0.025% one drop into affected eye twice daily; - ibuprofen 400 mg one tablet with food or milk by	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 51 mouth every six hours as needed; - Xarelto 20 mg one tablet with food once daily; - amlodipine besylate 5 mg one tablet by mouth once daily; - atorvastatin calcium 40 mg one tablet by mouth once daily; - loratadine 10 mg one tablet by mouth once daily; - losartan potassium 100 mg one tablet by mouth once daily; - metformin hydrochloride (hcl) 500 mg one tablet with food by mouth twice daily; - metoprolol tartrate 25 mg one tablet with food by mouth twice daily; - omeprazole 20 mg one capsule thirty minutes before morning meal by mouth once daily; - tamsulosin hcl 0.4 mg one capsule by mouth once daily; - ferrous sulfate 325 mg one tablet with food by mouth three times per week; - Ventolin hydrofluoroalkane (HFA) 108 mcg per act two puffs via inhalation as needed every four hours; - Lasix 20 mg one tablet as needed by mouth once daily; and - acetaminophen 500 mg one to two tablets as needed every six hours; New medications ordered on August 14, 2024, included: - vitamin C 500 mg one tablet by mouth once daily with iron pill; and - fish oil 1000 mg one capsule by mouth once daily. R1's record did not contain any orders since the August 14, 2024, MD visit. R1's MAR, dated October 2024, indicated R1 received the following medications: - Xarelto 20 mg one tablet with food daily;	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 52 - amlodipine 5 mg one tablet by mouth once daily; - atorvastatin calcium 40 mg one tablet once daily; - loratadine 10 mg one tablet daily; - losartan potassium 100 mg one tablet by mouth daily; - metformin hcl 500 mg one tablet by mouth twice daily with meals; - metoprolol 25 mg one tablet by mouth with food twice daily; - omeprazole 20 mg one capsule thirty minutes before morning meal daily; - tamsulosin hcl 0.4 mg one capsule daily; - ferrous sulfate 325 mg one tablet by mouth three times per week; - ascorbic acid 500 mg one tablet daily with iron; - Ventolin HFA two puffs as needed via inhalation; - Lasix daily one tablet by mouth once daily; - Tylenol one tablet by mouth as needed; and - Tylenol one tablet by mouth every six hours as needed. On October 23, 2024, at 11:45 a.m., the surveyor and CNS-A reviewed a list of discrepancies the surveyor had identified between R1's physician orders and October 2024 MAR. The discrepancies included a list of medications that were on the document licensee referred to as current orders but not on the October 2024 MAR, two orders that were included on the orders and MAR, but direction was not clear, and medications from the MAR that lacked indication, route, or dose. The list reviewed from the orders but not included on the MAR: - Advair Diskus 250-50 mcg per act one puff via inhalation twice daily; - Paxlovid (300/100 therapy pack) two capsules of 150 mg and one capsule of 100 mg by mouth	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 53 two times daily; - nebulizer to use for duoneb; - albuterol sulfate 2.5 mg per 3ml 0.083% 3 ml inhalation every 4 hours; - prednisone 20 mg one tablet by mouth once daily for five days with asthma flare; - robafen DM cough syrup 100 mg per 5 ml take 10 ml as needed every four hours; - Tussin DM 10 mg/ 5 ml take 10 ml as needed by mouth every four hours; - Ketotifen fumarate 0.025% one drop into affected eye twice daily; - ibuprofen 400 mg one tablet with food or milk by mouth every six hours as needed; and - fish oil 1000 mg one capsule by mouth once daily. The list reviewed that were included on the orders and the MAR but the directions were not clear: - Lasix 20 mg one tablet as needed by mouth once daily; and - vitamin C 500 mg one tablet by mouth once daily with iron pill. On October 23, 2024, at 11:45 a.m., CNS-A stated R1 did not have a nebulizer and had not used one since they moved to the facility. CNS-A stated they had not asked the physician about the medications listed on the orders that were not transcribed to the MAR including the Paxlovid, albuterol sulfate, Ketotifen fumarate, robafen DM, Tussin DM, prednisone, ibuprofen, Advair Diskus, or fish oil. CNS-A verified R1 had not been taking any of the medications listed. CNS-A stated they had not clarified if the Vitamin C should be administered every day or only on the three days weekly that R1 took their ferrous sulfate (iron pill). CNS-A verified the Vitamin C had been transcribed onto the MAR as daily and administered all seven days per week.	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 54 On October 23, 2024, at 4:23 p.m., The surveyor asked R1 when they stopped taking their inhaler. R1 stated they still used two inhalers and managed them on their own. R1 had ULP-D get their inhaler from under the pillow on the bed in their room. R1 had one Ventolin HFA inhaler that showed thirty-three actuations left on the counter that would have started at 90. The date R1 obtained the inhaler was not known. The inhaler was clean and still in good use with an expiration date of July 2025. R1 stated they took the Ventolin inhaler with them when they left the house and used it when they had shortness of breath or coughing. R1 stated they ran out of their second inhaler the day before and had called their son to help with refilling it. R1's son had refilled the second inhaler from the pharmacy and was scheduled to deliver it to R1 that evening. R1 did not remember the name of the second inhaler but told the surveyor it was a purple circle that they administered two times every day to prevent shortness of breath and coughing. On October 23, 2024, at 4:30 p.m., registered nurse (RN)-E called R1's clinic and scheduled an in-person appointment for October 24, 2024, for medication reconciliation. On October 23, 2024, at 5:41 p.m., CNS-A sent a text message to the surveyor that included a picture of the inhaler R1's son delivered to the facility. It was fluticasone propionate and salmeterol DISKUS inhalation powder 250 mcg and 50 mcg. The label indicated it was prescribed to R1 by their primary physician and the directions were for one puff inhalation twice a day for asthma. R1's record lacked evidence that a medication	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 55 assessment including identification and review of all medications the resident was known to be taking including indications for medications, side effects, contraindications, and actions to address these issues occurred. R2 R2 was admitted to the licensee and began receiving assisted living services on May 28, 2024. R2's diagnoses included hypertension, hereditary and idiopathic neuropathy. R2's Service Plan/ Addendum to Contract-Waiver, dated May 28, 2024, indicated R2 received medication administration, assistance with dressing, grooming, bathing, housekeeping, shopping, and socialization. R2's Summary of Today's Visit, dated August 27, 2024, and manually signed by R2's physician indicated the following medications to be currently ordered for R2: - gabapentin 300 mg one capsule by mouth one time daily at bedtime; - atorvastatin calcium 20 mg one tablet by mouth once daily; - cholecalciferol (Vitamin D) 125 mcg one tablet by mouth once daily; - amlodipine besylate 5 mg one tablet once daily; - hydrochlorothiazide 25 mg one tablet daily in the morning; and - Biotine as directed on package for dry mouth. R2's MAR, dated October 2024, indicated R2 received the following medications: - gabapentin 300 mg one capsule daily at 8:00 p.m.; - atorvastatin calcium 20 mg one tablet once	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 56 daily; - Vitamin D 125 mcg one tablet once daily; - amlodipine besylate 5 mg one tablet once daily; and - hydrochlorothiazide 25 mg one tablet once daily. On October 23, 2024, at 1:30 p.m., CNS-A stated they did not have Biotine included in R2's medication supply and did not think they had ever received it from the pharmacy. CNS-A stated they did not think R2 had dry mouth. R2's record lacked evidence that a medication assessment including identification and review of all medications the resident was known to be taking including indications for medications, side effects, contraindications, and actions to address these issues occurred. On October 23, 2024, at 1:38 p.m., CNS-A stated their process for medication reconciliation was to review new orders or appointment summary with current orders and MAR then update the electronic medical record with new changes that had been signed by the physician. CNS-A stated if the new medication list did not match the MAR or resident record, they should clarify with the physician to ensure the resident was taking the correct medications. When asked why there were several medications that still needed corrections, CNS-A stated they must have missed the orders for R1. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the assessment for medication management must be face to face with the resident and included: - a reconciliation of the medications the resident is known to be taking; - identification of indications for all of the	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 57 medications; - identification of potential side effects; - identification of contraindications; - identification of adverse reactions and how to address those issues; and - interventions to prevent diversion of the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01730	Continued From page 58 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 October 21, 2024, at 11:40 a.m., CNS-A stated a medication assessment was completed	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
01730	Continued From page 59 on admission for each new resident and the individualized medication plan was developed based on the assessment. The plan was reviewed at each ongoing reassessment. R1 R1 was admitted to the licensee and began receiving assisted living services on February 29, 2024. R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia. R1's Service Plan/ Addendum to Contract-Waiver, dated July 17, 2024, indicated R1 received medication administration, assistance with dressing, grooming, bathing, housekeeping, laundry, and socialization. R2 R2 was admitted to the licensee and began receiving assisted living services on May 28, 2024. R2's diagnoses included hypertension, hereditary and idiopathic neuropathy. R2's Service Plan/ Addendum to Contract-Waiver, dated May 28, 2024, indicated R2 received medication administration, assistance with dressing, grooming, bathing, housekeeping, shopping, and socialization. DESCRIPTION OF SERVICES PROVIDED FOR R1 AND R2 On October 22, 2024, at 1:57 p.m., the surveyor observed the medication storage area. The storage area was a locked file cabinet with drawers for each residents' medications. R1's drawer contained oral medications that were in	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01730	Continued From page 60 prescription bottles, one bottle of eye drops, and two inhalers. There were two one-week medication boxes that were both empty. R2's drawer contained three medication bottles and small plastic cups. On October 22, 2024, at 3:29 p.m., the surveyor observed unlicensed personnel (ULP)-D prepare and administer medications for R1. ULP-D removed the following medications from the prescription bottles in R1's drawer: - amlodipine 5 milligrams (mg) and - tamulosin hydrochloride (hcl) 0.4 mg. ULP-D put each medication into a plastic cup and brought the cup to R1. R1 swallowed the medications with water. R1 and R2's Individual Medication Management Plans indicated their medications were set up by the registered nurse (RN) weekly and staff provided medication reminders at scheduled times. On October 23, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-A stated when they documented performing a weekly medication set up what they meant was they had verified delivery of correct medications from the pharmacy and gone through the medication cabinet weekly to make sure each resident had the correct medications, adequate supplies, and removed any expired medications. CNS-A verified they did not set up medications for either resident and the ULPs provided medication administration of all medications, and neither resident received medication reminders. MEDICATION RECONCILLIATION FOR R1 and R2 R1	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01730	Continued From page 61 R1's record contained a Summary of Today's Visit, dated August 14, 2024. The document was manually signed by R1's physician indicated the following medications and equipment to be currently ordered for R1: - Advair Diskus 250-50 micrograms (mcg) per actuation (act) one puff via inhalation twice daily; - Paxlovid (300/100 therapy pack) two capsules of 150 mg and one capsule of 100 mg taken together by mouth two times daily; - nebulizer to use for duoneb; - albuterol sulfate 2.5 mg per 3 milliliters (ml) 0.083% 3 ml inhalation every 4 hours; - prednisone 20 mg one tablet by mouth once daily for five days with asthma flare; - robafen DM cough syrup 100 mg per 5 ml take 10 ml as needed every four hours; - Tussin DM 10 mg per 5 ml take ten ml as needed by mouth every four hours; - Ketotifen fumarate 0.025 percent (%) one drop into affected eye twice daily; - ibuprofen 400 mg one tablet with food or milk by mouth every six hours as needed; - Xarelto 20 mg one tablet with food once daily; - amlodipine besylate 5 mg one tablet by mouth once daily; - atorvastatin calcium 40 mg one tablet by mouth once daily; - loratadine 10 mg one tablet by mouth once daily; - losartan potassium 100 mg one tablet by mouth once daily; - metformin hcl 500 mg one tablet with food by mouth twice daily; - metoprolol tartrate 25 mg one tablet with food by mouth twice daily; - omeprazole 20 mg one capsule thirty minutes before morning meal by mouth once daily; - tamsulosin hcl 0.4 mg one capsule by mouth once daily;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01730	Continued From page 62 - ferrous sulfate 325 mg one tablet with food by mouth three times per week; - Ventolin hydrofluoroalkane (HFA) 108 mcg per act two puffs via inhalation as needed every four hours; - Lasix 20 mg one tablet as needed by mouth once daily; and - acetaminophen 500 mg one to two tablets as needed every six hours; On the document listed as new medications ordered on August 14, 2024, included: - vitamin C 500 mg one tablet by mouth once daily with iron pill (ferrous sulfate); and - fish oil 1000 mg one capsule by mouth once daily. R1's record did not contain any additional orders to start, stop, or clarify any medications since the August 14, 2024, MD visit. R1's MAR, dated October 2024, indicated R1 received the following medications: - Xarelto 20 mg one tablet with food daily; - amlodipine 5 mg one tablet by mouth once daily; - atorvastatin calcium 40 mg one tablet once daily; - loratadine 10 mg one tablet daily; - losartan potassium 100 mg one tablet by mouth daily; - metformin hcl 500 mg one tablet by mouth twice daily with meals; - metoprolol 25 mg one tablet by mouth with food twice daily; - omeprazole 20 mg one capsule thirty minutes before morning meal daily; - tamsulosin hcl 0.4 mg one capsule daily; - ferrous sulfate 325 mg one tablet by mouth three times per week; - ascorbic acid 500 mg one tablet daily with iron; - Ventolin HFA two puffs as needed via inhalation;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01730	Continued From page 63 - Lasix daily one tablet by mouth once daily; - Tylenol one tablet by mouth as needed; and - Tylenol one tablet by mouth every six hours as needed. On October 23, 2024, at 11:45 a.m., the surveyor and CNS-A reviewed a list of discrepancies the surveyor had identified between R1's physician orders and October 2024 MAR. The discrepancies included a list of medications that were on the document licensee referred to as current orders but not on the October 2024 MAR, two orders that were included on the orders and MAR, but direction was not clear, and medications from the MAR that lacked indication, route, or dose. The list reviewed from the orders but not included on the MAR: - Advair Diskus 250-50 mcg per act one puff via inhalation twice daily; - Paxlovid (300/100 therapy pack) two capsules of 150 mg and one capsule of 100 mg by mouth two times daily; - nebulizer to use for duoneb; - albuterol sulfate 2.5 mg per 3ml 0.083% 3 ml inhalation every 4 hours; - prednisone 20 mg one tablet by mouth once daily for five days with asthma flare; - robafen DM cough syrup 100 mg per 5 ml take 10 ml as needed every four hours; - Tussin DM 10 mg/ 5 ml take 10 ml as needed by mouth every four hours; - Ketotifen fumarate 0.025% one drop into affected eye twice daily; - ibuprofen 400 mg one tablet with food or milk by mouth every six hours as needed; and - fish oil 1000 mg one capsule by mouth once daily.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
01730	Continued From page 64 The list reviewed that were included on the orders and the MAR but the directions were not clear: - Lasix 20 mg one tablet as needed by mouth once daily; and - vitamin C 500 mg one tablet by mouth once daily with iron pill. On October 23, 2024, at 11:45 a.m., CNS-A stated R1 did not have a nebulizer and had not used one since they moved to the facility. CNS-A stated they had not asked the physician about the medications listed on the orders that were not transcribed to the MAR including the Paxlovid, albuterol sulfate, Ketotifen fumarate, robafen DM, Tussin DM, prednisone, ibuprofen, Advair Diskus, or fish oil. CNS-A verified R1 had not been taking any of the medications listed. CNS-A stated they had not clarified if the Vitamin C should be administered every day or only on the three days weekly that R1 took their ferrous sulfate (iron pill). CNS-A verified the Vitamin C had been transcribed onto the MAR as daily and administered all seven days per week. R2 R2's Summary of Today's Visit, dated August 27, 2024, and manually signed by R2's physician indicated the following medications to be currently ordered for R2: - gabapentin 300 mg one capsule by mouth one time daily at bedtime; - atorvastatin calcium 20 mg one tablet by mouth once daily; - cholecalciferol (Vitamin D) 125 mcg one tablet by mouth once daily; - amlodipine besylate 5 mg one tablet once daily; - hydrochlorothiazide 25 mg one tablet daily in the morning; and - Biotine as directed on package for dry mouth.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01730	Continued From page 65 R2's MAR, dated October 2024, indicated R2 received the following medications: - gabapentin 300 mg one capsule daily at 8:00 p.m.; - atorvastatin calcium 20 mg one tablet once daily; - Vitamin D 125 mcg one tablet once daily; - amlodipine besylate 5 mg one tablet once daily; and - hydrochlorothiazide 25 mg one tablet once daily. On October 23, 2024, at 1:30 p.m., CNS-A stated they did not have Biotine included in R2's medication supply and did not think they had ever received it from the pharmacy. CNS-A stated they did not think R2 had dry mouth. On October 23, 2024, at 1:38 p.m., CNS-A stated their process for medication reconciliation was to review new orders or appointment summary with current orders and MAR and updated the electronic medical record with new changes that had been signed by the physician. CNS-A stated if the new medication list did not match the MAR or resident record, they should clarify with the physician to ensure the resident was taking the correct medications. When asked why there were several medications that did not match from the orders to the MARs for current residents, CNS-A stated they must have missed those. ENSURING MEDICATION REFILLS WERE ORDERED TIMELY FOR R1 R1's MAR, dated October 2024, indicated R1 received amlodipine 5 mg one tablet every day at 2:00 p.m. On October 22, 2024, at 1:57 p.m., the surveyor planned to observe ULP-D prepare and administer medications for R1. ULP-D washed	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01730	Continued From page 66 their hands, told R1 they were going to prepare their 2:00 p.m. medication, reviewed the MAR, looked at the labels of all medication bottles in R1's drawer. ULP-D was not able to locate R1's amlodipine. ULP-D asked CNS-A for support. CNS-A looked at all of the prescription bottles in the drawer and determined the medication was not there. CNS-A called the pharmacy and ordered the medication from the pharmacy. It was delivered at 3:25 p.m. R1's Individualized Medication Management Plan, dated July 31, 2024, indicated the RN was responsible for monitoring medication supplies and ordering them as needed. On October 23, 2024, at 9:30 a.m., CNS-A stated they went through the medication cabinet weekly to make sure each resident had the correct medications and adequate supplies. CNS-A stated they did not know what happened that R1 ran out of a medication. CNS-A stated the pharmacy indicated they had not received a call for reorder until they called on October 22. DESCRIPTION OF STORAGE FOR R1 R1's Individualized Medication Management Plan, dated July 31, 2024, indicated all of R1's medication were stored by licensee in a locked cabinet. On October 23, 2024, at 11:45 a.m., CNS-A stated they had not seen an order for Advair Diskus on R1's previous orders and that R1 had not had Advair Diskus since they moved to the facility. On October 23, 2024, at 4:23 p.m., the surveyor asked R1 when they stopped taking Advair. R1 stated they still used two inhalers and managed	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
01730	Continued From page 67 them on their own. R1 had ULP-D get their inhaler from under their pillow in their room. R1 had one Ventolin HFA inhaler that showed thirty-three actuations left on the counter that would have started at 90. The date R1 obtained the inhaler was not known. The inhaler was clean and still in good use with an expiration date of July 2025. R1 stated they took the Ventolin inhaler with them when they left the house and used it when they had shortness of breath or coughing. R1 stated they ran out of their second inhaler the day before and had called their son to help with refilling it. R1's son had refilled the second inhaler from the pharmacy and was scheduled to deliver it to R1 that evening. R1 did not remember the name of the second inhaler but told the surveyor it was a purple circle that they administered two times every day to prevent shortness of breath and coughing. CNS-A stated they were not aware R1 kept any medications in their room. On October 23, 2024, at 5:41 p.m., CNS-A sent a text message to the surveyor that included a picture of the inhaler R1's son delivered to the facility. It was fluticasone propionate and salmeterol DISKUS inhalation powder 250 mcg and 50 mcg. The label indicated it was prescribed to R1 by their primary physician and the directions were for one puff inhalation twice a day for asthma. On October 24, 2024, at 2:28 p.m., CNS-A stated earlier that day, they had observed R1 administer their inhalers and authorized R1 to maintain independent storage of their inhalers. CNS-A stated they had not documented the observation or plan. R1's record included an Individualized Medication	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
01730	Continued From page 68 Management Plan, dated July 31, 2024. The plan lacked accuracy and implementation of the following required content: - an accurate statement describing the medication management services that were provided; - maintaining the medication management record when there had been changes; - completion of medication reconciliation; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. R2's record included an Individualized Medication Management Plan, dated September 10, 2024. The plan lacked implementation of the following required content: - an accurate statement describing the medication management services that were provided; - maintaining the medication management record when there had been changes; and - completion of medication reconciliation. The licensee's undated Individualized Medication Management Plan and Record policy indicated an individualized medication management plan would be developed based on the needs and preferences of each resident. The RN would develop the resident's medication record with detailed information about the medications staff would be managing. The plan would include the following content: - a statement describing the medication management services that would be provided;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
01730	Continued From page 69 - description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. The policy indicated the RN would keep each resident's plan up to date and consistent with prescriber orders and with the needs and preferences of the resident. In addition, "medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01750	Continued From page 70 must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide specific written instructions for medication administration when delegated to unlicensed personnel (ULP) for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 and began receiving assisted living services on February 29, 2024. R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia. R1's Service Plan/ Addendum to Contract-Waiver, dated July 17, 2024, indicated R1	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01750	Continued From page 71 received medication administration, assistance with dressing, grooming, bathing, housekeeping, laundry, and socialization. On October 22, 2024, at 3:36 p.m., the surveyor observed ULP-D prepare and administer medications for R1. R1's Summary of Today's Visit, dated August 14, 2024, included a medication list that was manually signed by R1's physician and considered to be R1's current orders. The orders indicated Lasix 20 mg one tablet as needed by mouth once a day. R1's Medication Administration Record (MAR), dated October 2024 indicated R1 was to receive Lasix one tablet by mouth once a day. The documentation on the MAR indicated Lasix was not administered any days in October 2024. On October 23, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated they did not realize the MAR lacked dose, indication, direction the medication was as needed and not timed for R1's as needed Lasix. CNS-A stated they would want staff to administer the as needed Lasix if R1 demonstrated weight gain or swelling in their lower extremities. CNS-A stated the specific parameters of when staff would administer the Lasix were not provided by the physician and would need to be clarified. R1's record lacked specific written instructions for ULPs to determine what symptoms indicated as needed Lasix administration or R1. R1's record lacked specific written instructions for measurement of weight, edema, or shortness of breath that might contribute to clinical monitoring of as needed Lasix.	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01750	Continued From page 72 The licensee's undated Delegation of Nursing Tasks and Therapy Tasks policy indicated the purpose of the policy was to provide direction and guidance for safe and effective nursing care delegated to unlicensed personnel. The policy indicated when a task was delegated to ULPs, the licensee would ensure the registered nurse had: - instructed the ULP in the proper methods to administer the delegated task and the ULP had demonstrated the ability to competently follow the procedures; - specified in writing detailed instructions for each resident and documented those instructions in the resident's record; - communicated with the ULP about the individual needs of the resident; and - the ULP would be trained to the task in the facility setting and would return demonstration of the task to be performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 73 in a securely locked location for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 and began receiving assisted living services on February 29, 2024. R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia. R1's Service Plan/ Addendum to Contract-Waiver, dated July 17, 2024, indicated R1 received medication administration, assistance with dressing, grooming, bathing, housekeeping, laundry, and socialization. R1's Individualized Medication Management Plan, dated July 31, 2024, indicated R1 required assistance with medication administration and that all R1's medications were securely stored by licensee in a locked cabinet. On October 23, 2024, at 4:23 p.m., R1 stated they used two inhalers and managed them on their own. R1 stated they had run out of one yesterday and had their son reorder from the pharmacy. R1 had unlicensed personnel (ULP)-D get their inhaler from under their pillow in their	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 74 room. The surveyor and clinical nurse supervisor (CNS)-A observed ULP-D retrieve one Ventolin hydrofluoroalkane (HFA) inhaler from under R1's pillow. On October 23, 2024, at 4:23 p.m., CNS-A stated they were not aware R1 kept any medications in their room. On October 24, 2024, at 2:28 p.m., CNS-A stated earlier that day they had observed R1 administer their inhalers and authorized R1 to maintain independent storage of their inhalers. CNS-A stated they had not documented the observation or plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01940	Continued From page 75 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to prepare and include in the service plan a written statement of the treatment or therapy services that were provided to the resident for one of one resident with treatments (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an 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 and began receiving assisted living services on February 29, 2024.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01940	Continued From page 76 R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia. R1's Service Plan/ Addendum to Contract-Waiver, dated July 17, 2024, indicated R1 received medication administration, assistance with dressing, grooming, bathing, housekeeping, laundry, and socialization. R1's Summary of Today's Visit, dated August 14, 2024, was manually signed by the physician and indicated R1 was seen in the clinic that day. The summary included a list of current medications and equipment that included: - blood glucose monitor as directed; - lancets as directed externally three times a day; - blood glucose test strips as directed three per day; - Accu-Chek Guide with device as directed for Diabetes management; - FreeStyle Libre 2 reader as directed for Diabetes management; and - Global Inject Ease Lancets as directed three times a day. On October 22, 2024, at 11:20 a.m., the surveyor observed unlicensed personnel (ULP)-D check R1's blood glucose level using continuous glucose monitoring. ULP-D scanned the sensor on R1's arm with a specific mobile device and reported a result of 171. On October 21, 2024, at 5:02 p.m., clinical nurse supervisor (CNS)-A stated R1 had used a continuous glucose monitor since they moved into facility. The staff checked R1's blood glucose level twice daily. CNS-A stated they changed the continuous glucose meter sensor in R1's arm every fourteen days.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
01940	Continued From page 77 R1's record contained an Individualized Treatment and Therapy Plan, dated October 12, 2024, however, lacked inclusion of the treatment of checking R1's blood glucose level twice daily on the signed service plan. On October 23, 2024, at 11:45 a.m., CNS-A reviewed the signed service plan dated July 17, 2024. CNS-A verified the service plan did not include anything related to R1's blood glucose monitoring. The licensee's undated Treatment and Therapy Management Plan policy indicated that treatment or therapy services would be incorporated into the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01960	Continued From page 78 by: Based on observation, interview, and record review, the licensee failed to document the treatment procedure of changing the blood glucose monitoring sensor for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an 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 and began receiving assisted living services on February 29, 2024. R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia. R1's Service Plan/ Addendum to Contract-Waiver, dated July 17, 2024, indicated R1 received medication administration, assistance with dressing, grooming, bathing, housekeeping, laundry, and socialization. R1's Summary of Today's Visit, dated August 14, 2024, was manually signed by the physician and indicated R1 was seen in the clinic that day. The summary included a list of current medications and equipment that included: - blood glucose monitor as directed; - lancets as directed externally three times a day; - blood glucose test strips as directed three per	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01960	Continued From page 79 day; - Accu-Chek Guide with device as directed for Diabetes management; - FreeStyle Libre 2 reader as directed for Diabetes management; and - Global Inject Ease Lancets as directed three times a day. On October 24, 2024, at 2:28 p.m., CNS-A stated they changed R1's arm sensor every fourteen days. CNS-A stated they did not keep track of when the sensor was due to be changed but it stopped working when it was due to be changed and staff called them. When CNS-A received that notification from staff they came to the facility and changed the sensor. CNS-A stated they did not document when they changed the sensor. CNS-A stated they entered a progress note when they had scheduled visits with the residents but when they stopped by the facility and completed a brief task, they did not document. The licensee's undated Treatment and Therapy Management Plan policy indicated each treatment administered would be documented in the resident record to include the signature and title of the person who administered the treatment, the date, and time of treatment administration. In addition, when the treatment or therapy was not administered as ordered, the facility would document the reason why it was not administered, communicate with prescriber as needed, and any follow up procedures that were provided to meet the resident need. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422			
(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
01970	Continued From page 80	01970			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure there were up to date written or electronically recorded orders from an authorized prescriber for all treatments and therapies for one of one resident with a treatment (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an 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 and began receiving assisted living services on February 29, 2024. R1's diagnoses included Type II Diabetes, hypertension, and benign prostatic hyperplasia.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01970	Continued From page 81 R1's Service Plan/ Addendum to Contract-Waiver, dated July 17, 2024, indicated R1 received medication administration, assistance with dressing, grooming, bathing, housekeeping, laundry, and socialization. On October 21, 2024, at 5:02 p.m., clinical nurse supervisor (CNS)-A stated staff checked R1's blood glucose level twice daily and additional times when R1 complained of any symptoms. CNS-A stated staff were directed to notify them if the results were below 70 or greater than 400. CNS-A stated they changed the continuous glucose meter sensor in R1's arm every fourteen days. On October 22, 2024, at 11:20 a.m., the surveyor observed unlicensed personnel (ULP)-D check R1's blood glucose level using continuous glucose monitoring. ULP-D scanned the sensor on R1's arm with a FreeStyle Libre 2 Reader mobile device and reported a result of 171. ULP-D recorded the result, time, and their initials in a notebook labeled as R1 Blood Glucose Records. R1's Summary of Today's Visit, dated August 14, 2024, was manually signed by the physician, and indicated R1 was seen in the clinic that day. No other signed physician orders were present in R1's record. The summary included the following medications and supplies related to R1's diabetic monitoring: - blood glucose monitor as directed; - lancets as directed externally three times a day; - blood glucose test strips as directed three per day; - Accu-Chek Guide with device as directed for Diabetes management;	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01970	Continued From page 82 - FreeStyle Libre 2 reader as directed for Diabetes management; and - Global Inject Ease Lancets as directed three times a day. On October 24, 2024, at 3:00 p.m., CNS-A reviewed R1's orders and stated the times for when blood glucose levels needed to be checked were not indicated. CNS-A stated they had always checked R1's blood glucose level twice daily but did not see that specified in the orders. They did not know if the physician meant the blood glucose levels needed to be checked three times daily or remain at two times based on the physician specifying equipment needs for lancets and test strips for three times daily. CNS-A stated they needed to clarify these things with the physician. On October 24, 2024, at 4:30 p.m., when asked where the direction for staff to contact the nurse if R1's blood glucose was less than 70 or more than 400 originated, CNS-A stated those number were selected by the nurse, and they did not have orders from the physician with specific parameters. The orders lacked specific frequency and times of day for blood glucose monitoring, frequency of changing the sensor for continuous blood glucose monitoring, supplies for sensor changes, and parameters with directions of what licensee should do and when to notify the physician for designated out of range blood glucose readings. The licensee's undated Treatment and Therapy Management Plan policy indicated orders must be obtained from an authorized provider before the treatment and therapy services could begin. The orders needed to include the "name of the resident, a description of the treatment or therapy	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER TAMAY HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5824 42ND AVENUE NORTH CRYSTAL, MN 55422		
(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
01970	Continued From page 83 to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy". Orders would be maintained in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			

Type: Follow-Up
Date: 10/23/24
Time: 08:18:44
Report: 8041241210

Food and Beverage Establishment Inspection Report

Page 1

Location:

Tamay Home Healthcare LLC
5824 42nd Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:

ID #: 0039229
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9523937857
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 previously issued on 10/21/24 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER ON SITE. PROVIDE A THIN PROBE THERMOMETER.

Issued on: 10/21/24

Comply By: 10/28/24

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.

NO TEMPERATURE INDICATOR ON SITE FOR MEASURING THE DISHWASHER UTENSIL SURFACE TEMPERATURE. THERMAL STRIP PROVIDED DURING INSPECTION TO VERIFY DISH MACHINE UTENSIL SURFACE TEMP.

Issued on: 10/21/24

Comply By: 10/28/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

TWO CABINET DRAWERS IN THE KITCHEN ARE BROKEN/OFF TRACK.

Issued on: 10/21/24

Comply By: 11/22/24

Type: Follow-Up
Date: 10/23/24
Time: 08:18:44
Report: 8041241210
Tamay Home Healthcare LLC

Food and Beverage Establishment
Inspection Report

No NEW orders were issued during this inspection.

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

The dishwasher has been repaired. Picture of thermolabel sent to inspector showing the showing the dishwasher achieved a utensil surface temperature of at least 160F for sanitizing.

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 8041241210 of 10/23/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Douglas Ayega
Owner

Signed: _____
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us

Type: Full
Date: 10/21/24
Time: 12:00:00
Report: 8041241208

Food and Beverage Establishment Inspection Report

Page 1

Location:

Tamay Home Healthcare LLC
5824 42nd Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:

ID #: 0039229
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9523937857
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.

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.

THE DISHWASHER IS NOT WORKING. USE ALTERNATIVE MEASURES TO SANITIZE UNTIL DISHWASHER IS REPAIRED. FACT SHEET SENT WITH REPORT.

Comply By: 10/21/24

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER ON SITE. PROVIDE A THIN PROBE THERMOMETER.

Comply By: 10/28/24

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.

NO TEMPERATURE INDICATOR ON SITE FOR MEASURING THE DISHWASHER UTENSIL SURFACE TEMPERATURE. THERMAL STRIP PROVIDED DURING INSPECTION TO VERIFY DISH MACHINE UTENSIL SURFACE TEMP.

Comply By: 10/28/24

Type: Full
Date: 10/21/24
Time: 12:00:00
Report: 8041241208
Tamay Home Healthcare LLC

Food and Beverage Establishment Inspection Report

4-500 Equipment Maintenance and Operation
4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
TWO CABINET DRAWERS IN THE KITCHEN ARE BROKEN/OFF TRACK.
Comply By: 11/22/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: frigidaire fridge: milk
Violation Issued: No

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

Inspection was completed with the owner, Douglas Ayega. Peggy Anderson was the lead Health Regulation Division Nurse Evaluator. Facility had three residents on site at time of inspection.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, solid surface countertop, popcorn ceiling and wood flooring.

Establishment has an Insignia dishwasher that has a sani rinse/high temp cycle, but it was not working at time of inspection. Establishment is working on repairing pr replacing the dishwasher. Verify dish machine is achieving a utensil surface temperature of at least 160F for sanitizing.

- Discussed the following:
- Employee illness policy and logging requirements
 - Handwashing
 - Glove-use and bare hand contact
 - Pest control
 - Food storage and preventing cross contamination
 - Date marking
 - Restrictions concerning serving a highly susceptible population
 - Vomit clean up process

Type: Full
Date: 10/21/24
Time: 12:00:00
Report: 8041241208
Tamay Home Healthcare 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 8041241208 of 10/21/24.

Certified Food Protection Manager Douglas Ayega

Certification Number: fm124715 Expires: 08/22/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Douglas Ayega
Owner

Signed:  _____
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us