Electronically Delivered

September 12, 2024

Licensee
St John Home Care LLC
3220 Nathan Lane North
Plymouth, MN 55441

RE: Project Number(s) SL34786015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 8, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34786	A. BUILDING: _____ B. WING _____	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	3220 NATHAN LANE NORTH PLYMOUTH, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34786015 On August 6, 2024, through August 8, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six (6) residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure that one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents for assistance with health or safety needs. Additionally, the licensee failed to develop and implement a written staffing plan using a staffing metrics to determine appropriate staffing levels which was updated twice per year.	0 470		

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0 470	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a licensee's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a capacity of six residents, and during the survey had a census of six residents. The licensee's August 2024 staff schedule, August 1, 2024, to August 31, 2024, indicated one staff member was scheduled per shift. On August 6, 2024, at 9:42 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A (who was also the facility owner) stated they did not have a staffing plan. LALD/CNS-A stated they had three shifts in a 24-hour period which had a consistent one staff member. LALD/CNS-A stated their staff shifts were at the following times with each shift overlapping with the previous shift for 30 minutes: -day shift, 7:00 a.m. to 3:30 p.m., one staff with Friday, Saturday, and Sunday two staff scheduled; -evening shift, 3:00 p.m. to 11:30 p.m., one with Friday, Saturday, and Sunday two staff scheduled; and -overnight shift, 11:00 p.m. to 7:30 a.m., one staff.	0 470		

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0 470	Continued From page 3 On August 5, 2024, at 9:59 a.m. LALD/CNS- A stated they were the only licensed staff and was onsite daily. LALD/CNS-A stated they were in current search of another registered nurse for assistance and backup. LALD/CNS-A stated they had two other sites seven minutes apart from each other with one site that had six residents and the other site that had one resident. LALD/CNS-A stated that staff would call LALD/CNS-A when assistance is needed at the sites. The licensee's 4.06 Staffing & Scheduling policy dated October 1, 2021, indicated: "1. The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. 2. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract b. Each resident's acuity level, as determined by the most recent assessment or individualized review c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises d. Whether the facility has a secured dementia care unit, and e. Staff experience, training, and competency. 3. The clinical nurse supervisor will develop a 24-hour daily staffing schedule that will identify: a. direct-care staff work schedules for each direct-care staff member showing all work shifts,	0 470		

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0 470	Continued From page 4 including days and hours worked, and b. the direct-care staff member's resident assignments or work location. 4. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. 5. Any employee requesting days off should, in writing, give the supervisor requested days off prior to the posting of the schedule. 6. If changes are needed after the posting of the schedule, employees are responsible to find their own qualified and capable replacement. Employees are responsible for filling out the appropriate PTO or trade request form and receive approval from the supervisor. 7. In case of an illness or emergency, employees must notify the supervisor by telephone at least two (2) hours in advance of the scheduled work time. For any reason employees are not available to work your scheduled shift, it is an employee's responsibility to make every attempt to find a St. John Home Care staff person to replace your shift. (Limited exceptions may include hospitalization, personal or family emergencies or death) 8. The supervisor has the authority, or may delegate the authority, to replace an employee with a temporary agency as needed." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		

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0 540	Continued From page 5	0 540		
0 540 SS=C	144G.41 Subd. 6 Family councils The facility must provide a family council with space and privacy for meetings, where doing so is reasonably achievable. The facility must designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the family council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the family council, take reasonably achievable steps to make residents and family members aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a family council with space and privacy for meetings, where doing so is reasonably achievable. This had the potential to affect all residents receiving assisted living services and their families. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On August 8, 2024, at 9:13 a.m., licensed	0 540		

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0 540	Continued From page 6 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they do not have a family council or provide space for one and stated, "I need to start doing this". The licensee's 2.34 Resident and Family Councils policy dated October 1, 2021, indicated the licensee would provide residents and families the opportunity, space, and privacy for meetings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 540		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a	0 660		

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0 660	Continued From page 7 tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes baseline testing for one of one employee unlicensed personnel (ULP)-B. 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). Findings include: The facility TB risk assessment was completed July 1, 2024, and indicated the facility was at a low risk for TB transmission. ULP-B was hired July 31, 2021, to provide direct care services to residents. ULP-B's employee record lacked documentation ULP-B completed a two-step TST or other blood test completed by the licensee upon hire. ULP-B's record included TB Testing Documentation - one step Mantoux dated April 11, 2017, and reading on April 13, 2017, with negative result 1,554 days before hire. On August 8, 2024, at 9:17 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the first step TB test was the only one in ULP-B's record and they would perform a TB test to meet the requirements.	0 660		

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0 660	Continued From page 8 The Minnesota Department of Health's Assisted Living Resources & Frequently Asked Questions (FAQs) dated August 8, 2024, indicated baseline TB screening includes: - assess for current symptoms of active TB disease; - assess TB history; - test for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test; and -a test should be dated with 90 days of hiring is acceptable. The licensee's 8.16 Tuberculosis Screening policy dated October 1, 2021, indicated, new staff would have a IGRA blood teste or a two-step mantoux. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 9 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, 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, 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 the residents). The findings include: The licensee's EPP dated January 1, 2022, lacked documentation including all the required elements of: - annual reviews/updates of plan; - missing resident quarterly review; - annual review/update on policies and	0 680		

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0 680	Continued From page 10 procedures; -subsistence needs for staff and patients; -procedures for tracking of staff and patients; -policies and procedures for sheltering; -policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a waiver declared by secretary; -names and contact information; -emergency officials contact information; Primary/alternate means for communication; - methods for sharing information; -sharing information on occupancy/needs; and -emergency prep training and testing. On August 8, 2024, at 9:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had oversight of the emergency plan and unaware of the required contents missing. The licensee's 9.02 Disaster Planning and Emergency policy dated October 1, 2021, indicated the licensee would have a plan in place that aligned with the facility requirements to comply with CMS Appendix Z. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in	0 780		

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0 780	Continued From page 11 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 (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).	0 780		

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0 780	Continued From page 12 The findings include: During facility tour on August 7, 2024, from approximately 11:00 a.m. through 12:00 p.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed that the smoke alarm located inside main floor sleeping room 1 and the smoke alarm located outside in the immediate vicinity of upper-level sleeping rooms 5 and 6 were not interconnected 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 alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour LALD/CNS-A tested the smoke alarms and verified the smoke alarms inside sleeping room 1 and outside in the immediate vicinity of sleeping rooms 5 and 6 were not interconnected so activation of one alarm activates all alarms throughout the facility. LALD/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	0 790		

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0 790	Continued From page 13 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on August 7, 2024, from approximately 11:00 a.m. through 12:00 p.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed that the portable fire extinguishers throughout the facility lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. The fire extinguishers located in the main floor kitchen and upper level at the top of the stairs lacked tags or documentation that indicated monthly inspections had been conducted. The fire extinguisher located in the basement at the bottom of the stairs lacked tags	0 790		

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0 790	Continued From page 14 or documentation that indicated annual testing and monthly inspections had been conducted. The surveyor explained to LALD/CNS-A that the portable fire extinguishers are required to be provided annual certification tags, and monthly visual inspection (quick checks) by a staff member. The visual inspection is required to ensure all extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition that would prevent their operation when needed. During the tour, LALD/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, 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	0 800		

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0 800	Continued From page 15 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 August 7, 2024, from approximately 11:00 a.m. through 12:00 p.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor made the following observations: The egress window in sleeping room 2, located on the upper floor, had hardware that was sticking and made it difficult to operate and open the window. Egress windows must be maintained so they can be opened in an emergency situation. The rear deck was being used by residents as a smoking area. There was an ashtray present, but ashes and several cigarette butts were observed on the deck and between the deck floorboards. The surveyor explained to LALD/CNS-A that the discarded cigarette butts and ashes were a potential fire hazard, and residents should be educated and told to use the ashtray. The electrical outlet outside the rear door leading onto the deck was missing its cover. Exterior outlets must have weatherproof covers installed and maintained so electrical components are not	0 800		

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0 800	Continued From page 16 exposed to the weather. The siding around the rear door leading to the deck was deteriorated and the house wrap under the siding was exposed to the exterior. Siding must be maintained weather resistant to prevent water from entering the wall assembly which could lead to rot and structural damage to the wall. The stairs leading to the basement were obstructed with boxes and other items stored on the stairs. The stairs were the only exit from the basement area. Exits must be kept clear of obstructions, so they are available in an emergency situation. LALD/CNS-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 17 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to conduct the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 18 During facility tour on August 7, 2024, from approximately 11:00 a.m. through 12:00 p.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed the fire evacuation maps were not posted on the upper floor or the basement of the facility. On August 7, 2024, at 12:00 p.m., (LALD/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 "Emergency Plan for St. John Home Care LLC", undated, failed to include the following: The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. 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 manual fire alarm boxes and automatic dialing to the fire department. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems stated in the policy.	0 810		

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0 810	Continued From page 19 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. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on August 7, 2024, at 12:15 p.m., LALD/CNS-A stated that they had a different policy, but it was not at this facility because they had another facility that was surveyed the week prior. The surveyor explained that the FSEP is meant to be specific to each facility and that each facility is required to have their own FSEP available at the facility at all times. LALD/CNS-A stated they understood the requirement. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to residents, at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire	0 810		

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0 810	Continued From page 20 and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During an interview on August 7, 2024, at 12:15 p.m., LALD/CNS-A stated that they did not have any documentation for staff or resident training. The surveyor explained the requirements for training staff at hire and twice annually and annually offering training to residents on the FSEP. LALD/CNS-A stated they understood the requirement. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation of drills conducted or planned for a future date. During an interview on August 7, 2024, at 12:15 p.m., LALD/CNS-A stated they were conducting drills 2 times per year but did not have any documentation. LALD/CNS-A stated they knew they need to conduct more drills and they have started to conduct them more frequently. The surveyor explained the requirement for fire drills and LALD/CNS-A stated they understood the requirement for frequency of fire drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440		

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01440	Continued From page 21 therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP)-B. 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	01440		

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01440	Continued From page 22 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on July 31, 2021, to provide direct care and services to the facility's residents. On August 6, 2024, at 11:23 a.m., the surveyor observed ULP-B administer medications to R1. ULP-B's employee record lacked documentation of a registered nurse (RN) supervising ULP-B performing a delegated task within 30 days of beginning work with the licensee. On August 8, 2024, at 9:23 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated "I don't have any answers for why that is missing. We now do monthly supervisions". The licensee's 6.18 Supervision of Staff dated October 1, 2021, indicated staff who provided assisted living services to licensees' residents would be supervised where the services are being provided to verify work is being perform competently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	01470		

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01470	Continued From page 23 (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss	01470		

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01470	Continued From page 24 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations for one of one employee unlicensed personnel (ULP)-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on July 31, 2021, to provide direct care services to residents at the assisted living facility. On August 6, 2024, at 11:23 a.m. ULP-B was observed assisting R1 with activities of daily living (ADLs) and medication administration.	01470		

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01470	Continued From page 25 ULP-B's employee records lacked the following required orientation content upon hire with a completion date of November 27, 2022: - an overview of the Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - the assisted living bill of rights; - handling or resident complaints, reporting of complaints, where to report; -consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of licensure; - principles of person-centered planning/service delivery; and -hearing loss (optional). On August 8, 2024, at 9:17 a.m. The licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated employee was hired at a previous sister location in 2021 and lacked required orientation upon survey results with corrections made for all employees in 2022 with all required orientation. The licensee's, 5.01 Orientation of Staff and Supervisors and Content dated October 1, 2021, indicated all staff must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee unlicensed personnel (ULP)-B received the required amount of dementia care training in the required time frame. This has the potential to affect all residents. This practice resulted in a level two violation (a	01530		

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01530	Continued From page 27 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired July 31, 2021, to provide direct care to the licensee's residents. ULP-B's employee record did not indicate a total of 8 hours of the required dementia training was completed with 160 hours of employee start date. On August 8, 2024, at 9:17 a.m. The licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated employee was hire at a previous sister location in 2021 and lacked required orientation upon survey results with corrections made for all employees in 2022 with all required orientation. The licensee's 5.03 Dementia Training policy dated October 1, 2021, indicated direct care staff will complete a minimum of 8 hours of initial training on dementia care topics and initial training will be completed within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 28 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool 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	01620		

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01620	Continued From page 29 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on July 1, 2020. R1's 90 Day Uniform Assessment Tool record dated October 1, 2023, January 2, 2024, April 2, 2024, and July 1, 2024, were one-page documents identified by licensed assisted living director/clinical nurse supervisor (CNS)-A as R1's last four consecutive 90-day RN assessments completed by LALD/CNS-A. The assessments lacked a full physical and cognitive assessment as required on the uniform assessment tool. The assessments failed to be developed and address the required content per Minnesota Administrative Rule 4659.0140 Subp. 2. B. (3). On August 8, 2024, at 9:15 a.m., LALD/CNS-A stated licensee performed a comprehensive assessment once a year that included all the elements of the uniform assessment tool, then used the one-page RN assessment for all other assessments during the year and was not aware of the Uniform Assessment Tool requirement for all 90-day assessments. The licensee's 6.03 Uniform Assessment Tool (Comprehensive Assessment) policy dates October 1, 2021, indicated licensee would use a uniform assessment tool that addressed all the required elements. No further information provided.	01620		

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01620	Continued From page 30 TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01730 SS=D	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; (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	01730		

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01730	Continued From page 31 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 interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on August 6, 2024, at 9:42 a.m., licensed assisted living direction/clinical nurse supervisor (LALD/CNS)-A indicated the licensee provided medication management services for the licensee's six residents. R1's record lacked a medication management plan to include the following required content: - type of medication storage system, based on resident's needs.	01730		

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01730	Continued From page 32 R1 was admitted for services on July 1, 2020, with diagnoses including type 2 diabetes mellitus. R1's Service Plan, signed by R1 on December 10, 2022, indicated R1 received assistance with meals, medications, medication set up and monitoring, personal laundry, manage orientation issues, shopping, assistance making appointments, housekeeping, and linen change. On August 6, 2024, at 11:23 a.m., with permission from R1, the surveyor observed unlicensed personnel (ULP)-B administer R1's medications. On August 8, 2024, at 9:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware R1's record lacked a medication management plan with the above required content. The licensee's Medication Storage policy dated October 1, 2021, indicated each resident's medications would be stored in consistent with the resident's medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.	01770		

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01770	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the residents). The findings include: R1 was admitted for services on July 1, 2020, with diagnoses including type 2 diabetes mellitus. R1's Service Plan, signed by R1 on December 10, 2022, indicated R1 received assistance with medications and medications set up and monitoring. R1's Care Plan Record dated, August 1, 2024, to August 31, 2024, indicated on August 3, 2024, ULP-B signed off the medication setup weekly at 8:00 a.m. R1's record lacked medication set-up documentation to include name of medication, quantity of dose, times to be administered, routes of administration, and name of person completing medication set-up by the nurse. On August 8, 2024, at 9:07 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated when they completed a	01770		

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01770	Continued From page 34 medication set-up, they initial the resident's medication administration record (MAR) under weekly medication set up. LALD/CNS-A stated that LALD/CNS-A sits with ULP-B to set up resident's medications for a nurse to verify correct medications are being set up. LALD/CNS-A stated that they will no longer have ULP-B set up resident's medications with LALD/CNS-A. The licensee's 7.09 Medication Management -Dosage Box Setup policy dated October 1, 2021, indicated a licensed nurse would set up resident dosage boxes timely and accurately and document on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not used beyond the expiration date for three of three residents (R1, R2, R3), and failed to ensure medications maintained bearing the open date label with legible information including the expiration date for time sensitive medications	01890		

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01890	Continued From page 35 for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, at 10:25 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, including a review of the locked medication room closet. The surveyor observed and confirmed the following with LALD/CNS-A: EXPIRED MEDICATIONS R1 -gabapentin 800 milligrams (mg) Expiration date: September 12, 2022, and second bubble pack October 12, 2022. R2 -tylenol 500 mg Expiration date: October 2023. -levothyroxine 75 micrograms (mcg) Expiration date: June 15, 2020 -certizine 10 mg Expiration date: December 2023 -vitamin B12 500 mcg Expiration date July 21, 2021 -Hydrocortisone 2.5% Expiration date December 2023 - five half unknown medication tablets and six whole unknown medication tablets on the bottom of the medication container. R3	01890		

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01890	Continued From page 36 -mirtazapine 15 mg Refill date after: December 13, 2023 -mirtazapine 15 mg in four bubble packs Expiration date: bubble pack one January 12, 2023, bubble pack two February 8, 2023; bubble pack three December 21, 2022, and bubble pack 4 February 8, 2024. OPEN DATE/TIME SENSITIVE MEDICATIONS R2 R2's lantus one empty pen and one opened pen contained original prescription label with information regarding the directions for use, resident's name, the pharmacy in which it had been issued. Each lantus pen lacked the date the insulin pen had been opened and expiration date. R1's medication administration record (MAR) form August 1, 2024, to August 31, 2024, indicated R1 received: - gabapentin 800 mg one tablet by mouth three times a day. R2's MAR from August 1, 2024, to August 31, 2024, indicated R2 received: - tylenol 500 mg take 2 tablets three times a day by mouth as needed; -levothyroxine 37.5 mcg take 0.5 tab by mouth daily; -certizine 10 mg by mouth daily; -vitamin B12 500 mcg take one tablet by mouth daily; -hydrocortisone 2.5% apply topically two times a day; and - lantus 100 units/ milliliters (mL) inject 30 units daily. R3's MAR August 1, 2024, to August 31, 2024, indicated R3 received: -mirtazapine 15 mg take 1.5 tablets by mouth	01890		

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01890	Continued From page 37 daily. On August 6, 2024, at 10:49 a.m., LALD/CNS-A stated there should not be expired medications in there and does not know why the expired medication are in there. LALD/CNS-A stated they had oversight of the licensee's medications and will dispose of expired medications. On August 6, 2024, at 11:17 a.m. LALD/CNS-A stated R2's insulin pens are not labeled with open date and once a pen is used the pen is disposed of and a new insulin pen would be opened. LALD/CNS-A stated unaware why the empty insulin pen is not disposed of. The licensee's 7.11 Medication Storage policy dated October 1, 2021, indicated the medications would be stored consistent with manufacture's recommendations. The licensee's 7.23 Medication disposal policy dated October 1, 2021, indicated medications for residents that have expired will be disposed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01940		

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01940	Continued From page 38 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; (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 interview and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of one resident (R1) who received treatments. 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	01940		

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01940	Continued From page 39 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted for services on July 1, 2020, with diagnoses including type 2 diabetes mellitus. R1's Service Plan, signed by R1 on December 10, 2022, indicated R1 received assistance with meals, medications, medication set up and monitoring, personal laundry, manage orientation issues, shopping, assistance making appointments, housekeeping, and linen change. R1's prescriber orders dated July 16, 2024, included blood glucose monitoring once daily. R1's assessment dated July 1, 2024, indicated R1 received blood glucose monitoring once per day by ULP. R1's treatment plan lacked the following: -written instructions for each treatment; and -resident specific instructions related to documentation of all treatments and/or therapies administered, or reason not administered, verified as administered and monitored to prevent complications or adverse reactions. On August 8, 2024, at 9:16 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated unaware of the required contents missing. The licensee's 7.05 Treatment and Therapy Management Plan policy dated October 1, 2021, read, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident to	01940		

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01940	Continued From page 40 contain: a. A written statement of the services to be provided b. Documentation of specific instructions that relate to providing the treatment or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented f. Frequency of supervision of personnel providing the delegated treatment or therapy services g. Verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions h. The treatment or therapy plan will be updated when there are changes No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *08/06/24*
Time: 13:00:00
Report: 8087241169

Food and Beverage Establishment Inspection Report

Location:

St John Home Care Llc
3220 Nathan Lane North
Plymouth, MN55441
Hennepin County, 27

Establishment Info:

ID #: 0038932
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9523001067
ID #:

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

No NEW orders were issued during this inspection.

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED WITH NURSE EVALUATOR JESSICA DETERS.

FLOORS, CABINETS, AND CEILINGS ARE NOT APPROVED BUT ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

ALL COLD HOLDING TEMPERATURES AND AMBIENT AIR TEMPERATURES MEASURED AT 41 DEGREES OR COLDER.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

DESIGNATED HAND WASHING SINKS IN THE KITCHENS.

INSPECTION REPORT EMAILED TO JESSICA DETERS AND DIRECTOR JOY AKINLOYE.

Type: Full
Date: *08/06/24*
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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 8087241169 of 08/06/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
JOY AKINLOYE
DIRECTOR

Signed:_____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us