Electronically Delivered

July 11, 2025

Licensee
Shelter Arm LLC
9444 Fallgold Parkway North
Brooklyn Center, MN 55443

RE: Project Number(s) SL38781016

Dear Licensee:

On May 30, 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 on April 2, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 2, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 2, 2025, found not corrected at the time of the May 30, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
2310-Appropriate Care And Services-144g.91 Subd. 4 (a)

The details of the violations noted at the time of this follow-up survey completed on May 30, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on May 30, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $500.00
0720-Access To Records-144g.43 Subd. 2

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38781	A. BUILDING: _____ B. WING _____	R 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELTER ARM LLC	9444 FALLGOLD PARKWAY NORTH BROOKLYN CENTER, MN 55443

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL38781016-1 On May 29, 2025, to May 30, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 2, 2025. At the time of the survey, there were four residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/ or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed April 2, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 340		

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0 340	Continued From page 2 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: Survey was completed on March 31, 2025, through April 2, 2025. The licensee received the final survey results on May 7, 2025. The longest period of correction was twenty-one days to be completed from May 7, 2025, to May 28, 2025. The surveyor initiated a follow up survey on May 29, 2025. On May 29, 2025, at 8:53 a.m., clinical nurse supervisor (CNS)-C stated the licensee had not documented a plan of correction for the citations issued at the last survey except for the citation regarding background studies (Tag 1290). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{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}		

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{0 480}	Continued From page 3 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}		

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{0 480}	Continued From page 4 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:	{0 480}	Not reviewed during survey	
{0 650} SS=D	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 infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	{0 650}		

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{0 650}	Continued From page 5 This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during the survey	
{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 tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a TB history and symptom screen for all the licensee's employees. 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	{0 660}		

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{0 660}	Continued From page 6 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: Survey was completed on March 31, 2025, through April 2, 2025. The licensee received the final survey results on May 7, 2025. This citation had correction date period of twenty-one days to be completed from May 7, 2025, to May 28, 2025. The surveyor initiated a follow up survey on May 29, 2025. Unlicensed personnel (ULP)-H was hired on October 3, 2024. ULP-H's Employee Screening Tools for TB dated October 3, 2024, indicated ULP-H did not have a history of TB; and a two-step within one to three weeks plus Employee Screening Tool would be needed upon new hire. ULP-H's undated Tuberculin Skin Test (TST) Report indicated ULP-H had a TST placed on November 1, 2024, and TST read on November 4, 2024. ULP-H's employee record lacked documentation of a second step TST. On May 29, 2025, at 3:40 p.m., clinical nurse supervisor (CNS)-C stated they provided everything they had for ULP-H's TB information to the surveyor. CNS-C stated all staff had their TB	{0 660}		

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{0 660}	Continued From page 7 testing completed so they did not know what the surveyor was requesting. The surveyor explained the current guidelines by the CDC included a two-step TST as part of the baseline TB screening for the TB testing. CNS-C stated not all staff complete a two-step TST as some do the blood test or a chest x-ray. CNS-C stated they were told by ULP-H, they did not need to go back to the clinic for further TB testing and then stated the clinic had also told them ULP-H did not need a two-step TST as well. No further information provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	{0 680}		

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{0 680}	Continued From page 8 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 of the residents). The findings include: Survey was completed on March 31, 2025, through April 2, 2025. The licensee received the final survey results on May 7, 2025. This citation had correction date period of twenty-one days to be completed from May 7, 2025, to May 28, 2025. The surveyor initiated a follow up survey on May 29, 2025. On May 29, 2025, at 12:42 p.m., clinical nurse supervisor (CNS)-C stated the licensee still had been working on the licensee's EPP as they had	{0 680}		

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{0 680}	Continued From page 9 to completely redo everything. No further information provided.	{0 680}		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that personnel records were readily available for access to the commissioner upon request. 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 May 29, 2025, at 12:42 p.m., the surveyor requested unlicensed personnel (ULP)-H's records for training and competencies by 2:30 p.m. On May 29, 2025, at 2:10 p.m., in an email, the	0 720		

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0 720	Continued From page 10 surveyor received ULP-H's Staff Training Transcript dated October 1, 2024, through May 29, 2025, and undated Transcripts. On May 29, 2025, at 3:31 p.m., the surveyor emailed the licensee a request for ULP-H's training competencies as these were not included in the records received. On May 29, 2025, at 3:40 p.m., clinical nurse supervisor (CNS)-C stated they had sent everything for ULP-H's education except for the education and competencies completed on paper. CNS-C stated they would have to send those documents tomorrow as they had left the facility. On May 30, 2025, at 8:17 a.m., in an email, the surveyor requested all ULP-H's competencies; and ULP-B's education, competencies, and supervision completed since the previous survey completed on March 31, 2025, through April 2, 2025. On May 30, 2025, at 9:51 a.m., CNS-C stated frustration with having other responsibilities and patient care they need to do and stated they did not have the time but could send the information later today and suggested 3:00 p.m. or 4:00 p.m. CNS-C had confirmed they had received the email with the records request that was sent previously. On May 30, 2025, at 10:12 a.m., in an email, the surveyor wrote to the licensee, "I understand you have other responsibilities, however, if you are not able to assist with getting the information to me, then please have someone help you with this. You have until 11:00 a.m. to get this information to me. If the information is not	0 720		

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0 720	Continued From page 11 received by 11:00 a.m., then the survey window will close, and I will proceed with the information I have received." On May 30, 2025, at 11:09 a.m., the surveyor sent an exit email due to no response for the additional records requested. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720		
{0 790} SS=C	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:	{0 790}	Not reviewed during survey	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the	{0 800}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38781	A. BUILDING: _____ B. WING _____	R 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELTER ARM LLC	9444 FALLGOLD PARKWAY NORTH BROOKLYN CENTER, MN 55443

(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 12 health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during survey	
{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 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	{0 810}		

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{0 810}	Continued From page 13 per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}		
{01320} SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by:	{01320}	Not reviewed during survey	
{01330} SS=F	144G.60 Subd. 4 (b) Unlicensed personnel	{01330}	Not reviewed during the survey	

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{01330}	Continued From page 14 (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by:	{01330}	Not reviewed during the survey	
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	{01440}		

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{01440}	Continued From page 15 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:	{01440}		
			Not reviewed during the survey	
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (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,	{01470}		

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{01470}	Continued From page 16 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 staff member 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 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:	{01470}	Not reviewed during the survey	

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{01470}	Continued From page 17	{01470}		
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation 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 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics	{01530}		

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{01530}	Continued From page 18 related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during the survey	
{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:	{01880}	Not reviewed during this survey.	
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R3) who utilized a side rail. This practice resulted in a level two violation (a	{02310}		

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{02310}	Continued From page 19 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: Survey was completed on March 31, 2025, through April 2, 2025. The licensee received the final survey results on May 7, 2025. This citation had correction date period of two days to be completed from May 7, 2025, to May 9, 2025. The surveyor initiated a follow up survey on May 29, 2025. On May 29, 2025, at 12:42 p.m., clinical nurse supervisor (CNS)-C stated the resident's family still needed to figure out where they had purchased the consumer side rail and told the licensee to look on Amazon (online retailer). CNS-C stated the family had to figure it out since they had purchased the consumer side rail. CNS-D stated the licensee did not have a manufacturer's guideline for the side rail as the family had not provided this yet. CNS-C stated the side rail was used to assist the resident with getting in and out of bed and the side rail was secured. CNS-C stated the only thing the last surveyor had an issue with was the licensee not having a manufacturer's guideline for the side rail. CNS-C stated they did not know the name of the	{02310}		

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{02310}	Continued From page 20 product but once they got the name, then they could look this up on Amazon to see it this product had been recalled. CNS-C stated the side rail was safe and if it was not safe then they would remove the side rail. No further information was provided.	{02310}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 7, 2025

Licensee
Shelter Arm LLC
9444 Fallgold Parkway North
Brooklyn Center, MN 55443

RE: Project Number(s) SL38781016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 2, 2025, 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.

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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL38781016-0 On March 31, 2025, through April 2, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four (4) residents receiving services under the Assisted Living Facility license. On April 1, 2025, an immediate correction order for tag identification number 1290 was issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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 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	0 480		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 2 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 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 31, 2025, 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	0 480		

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	38781	A. BUILDING: _____ B. WING _____	04/02/2025

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	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 infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented training and competencies as required by Minnesota Administrative Rule 4659.0190 Subpart 6 for one of two unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 4 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 by the licensee on January 22, 2025. ULP-B's 2.30 Medication Administration - Oral Meds form dated January 15, 2025, (seven days before ULP-B's identified hire date), was signed by clinical nurse supervisor (CNS)-C but lacked documentation ULP-B was trained and found competent to provide medication administration to residents. The licensee's March/April Schedule identified by CNS-C as licensee's current and accurate schedule dated March 24, 2025, through April 6, 2025, indicated ULP-B worked directly with residents on March 29, 2025, and March 30, 2025. On March 31, 2025, at 12:30 p.m., CNS-C stated when ULP-B was hired by the licensee, CNS-C provided training on all medication administration competency, but licensee did not accurately document the training and competency ULP-B received. CNS-C stated they had authenticated ULP-B's forms once the training was provided, but did not have ULP-B authenticate the form and complete the form. CNS-C stated all evidence of training would be maintained in each employee's respective record.	0 650		

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0 650	Continued From page 5 Minnesota Administrative Rule 4659.0190 Subpart 6 published August 11, 2021, indicated all training and competency must be documented and maintained in each employee's respected record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee	0 660		

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0 660	Continued From page 6 failed to complete a TB history and symptom screen for all the licensee's employees. 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: Unlicensed personnel (ULP)-A was hired on September 11, 2024. ULP-A's employee record lacked documentation of a completed TB history and symptom screen at time of ULP-A's hire. ULP-A's employee record included a referral form for a TB blood test, but no TB test results was documented. On March 31, 2025, at 2:10 p.m., clinical nurse supervisor (CNS)-C stated that ULP-A completed a TB blood test, and no licensee employee completed a TB history and screen at time of hire and was unaware of this requirement. CNS-C further stated the licensee would have all employees complete a TB history and symptom screen. The licensee's Tuberculosis Prevention and Control policy undated, indicated baseline screening is completed at time of hire for all direct care providers and testing results will be kept in each employee medical file. The Minnesota Department of Health (MDH)	0 660		

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0 660	Continued From page 7 guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. 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; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680		

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0 680	Continued From page 8 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 of the residents). The findings include: On March 31, 2025, at approximately 1:00 p.m., clinical nurse supervisor (CNS)-C provided a binder and stated the contents were the licensee's EPP. The licensee's EPP dated May 20, 2022, lacked an individualized plan to include all the required content below: -missing 2023 and 2024 annual review; -missing resident quarterly review;	0 680		

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0 680	Continued From page 9 -development of policies/procedures (P/P) based on HVA assessment for subsistence needs for staff and residents, tracking of staff and residents, medical documents, volunteers, and arrangement with other facilities; -names and contact information; -primary and alternate means for communication; -methods for sharing information; -LTC family notifications; and -EP training and testing program; On March 31, 2024, at approximately 2:00 p.m., CNS-C acknowledged the licensee's EPP lacked the above listed required content. CNS-C stated the licensee's EPP was a work in progress and was not aware of all the requirements of Appendix Z. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee's EPP would have an identified EEP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=C	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	0 790		

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0 790	Continued From page 10 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 one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 1, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with house manager (HM)-G. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800	Continued From page 11	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 1, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with house manager (HM)-G. The following was observed.	0 800		

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0 800	Continued From page 12 In the lower lever bathroom, there was water damage to the ceiling. There was staining on the ceiling and the drywall tape was coming loose from the ceiling. The exhaust vent for the gas fired clothes dryer was unhooked causing the dryer to vent into the facility. 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 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	0 810		

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0 810	Continued From page 13 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide 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: On April 1, 2025, house manager (HM)-G provided documents 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 Safety", dated May 12, 2021, failed to include the following: The FSEP included standard employee	0 810		

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0 810	Continued From page 14 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 provided FSEP was from a third-party provider and had not been updated to the specific facility. 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. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. HM-G lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. HM-G lacked documentation showing that staff have been trained on the fire safety and evacuation plan. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at	0 810		

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0 810	Continued From page 15 least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted on April 23, 2024, for all three shifts, January 21, 2025, January 20, 2025, and January 20, 2025. No other documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a Department of Human Services (DHS) background study (BGS) was submitted, cleared, and affiliated with the licensee's current assisted living facility's health facility identification (HFID) number for three of three unlicensed personnel ((ULP)-B, ULP-D,	01290		

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01290	Continued From page 16 ULP-E). Additionally, the licensee failed to provide continuous direct supervision of employees who did not have a cleared BGS and provided services to residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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: ULP-B, ULP-D, and ULP-E were hired on January 22,2025, January 7, 2025, and December 27, 2024, respectively. The licensee's March/April Schedule identified by clinical nurse supervisor (CNS)-C as licensee's current and accurate schedule dated March 24, 2025, through April 6, 2025, indicated ULP-B and ULP-D worked together on March 29, 2025, and March 30, 2025, with no other staff present. Additionally, ULP-D and ULP-E worked together on March 24, 2025, March 26, 2025, and March 28, 2025, with no other staff present. On March 31, 2025, at 8:10 a.m., this survey was initiated via an e-mail being sent to licensee's contact information. On March 31, 2025, at 8:13 a.m., the surveyor spoke with CNS-C via a phone call to inform licensee's survey was initiated and surveyors would arrive at licensee's address at 10:00 a.m.	01290		

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	38781	A. BUILDING: _____ B. WING _____	04/02/2025

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01290	Continued From page 17 to conduct the entrance conference. ULP-B's DHS Person Summary screenshot taken March 31, 2025, at 1:14 p.m., indicated ULP-B's first BGS submission by licensee was completed on March 31, 2025, at 11:26 a.m., after surveyor requested the BGS for ULP-B. ULP-B's BGS indicated ULP-B was able to provide services to residents but required supervision by another staff member who had a completed and cleared BGS at all times. ULP-D's DHS Person Summary screenshot taken March 31, 2025, at 1:12 p.m., indicated ULP-D's first BGS submission and affiliation to licensee's HFID by licensee was completed on March 31, 2025, at 9:22 a.m., after surveyor provided notice of licensee's survey initiation. ULP-E's DHS Person Summary screenshot taken March 31, 2025, at 1:16 p.m., indicated ULP-E's first BGS submission and affiliation to licensee's HFID by licensee was completed on March 31, 2025, at 9:29 a.m., after surveyor provided notice of licensee's survey initiation. On March 31, 2025, at 2:00 p.m., CNS-C stated licensee was aware all staff are required to have a cleared BGS and be affiliated with licensee's HFID, but was unsure why ULP-B, ULP-D, and ULP-E did not have a cleared BGS and affiliated with licensee's HFID. CNS-C stated licensee had failed to log back into DHS NetStudy BGS software to ensure all employees had a cleared BGS. Once survey was initiated CNS-C logged into the DHS NetStudy program and completed the required BGS processes for the three ULPs were did not have a cleared BGS. The licensee's undated 4.02 Background Studies	01290		

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01290	Continued From page 18 policy read, "No employee may provide direct services and have independent direct contact with any resident until acceptable result of the background study have been received." The NetStudy 2.0 System User Manual dated July 7, 2023, defined continuous, direct supervision as an individual who was within sight and hearing of the program's supervising individual to the extent that the program's supervising individual was capable at all times of intervening to protect the health and safety of the persons served by the program. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks.	01320		

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01320	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel ((ULP)-B) had completed training and competency evaluations in all required topics. This had the potential to affect all residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired by the licensee on January 22, 2025. ULP-B's Employee Orientation Checklist was dated by clinical nurse supervisor (CNS)-C on January 15, 2025, (seven days before ULP-B's identified hire date), and lacked documentation ULP-B received any orientation, training, or competency testing. The licensee's March/April Schedule identified by CNS-C as licensee's current and accurate schedule dated March 24, 2025, through April 6, 2025, indicated ULP-B worked directly with residents on March 29, 2025, and March 30, 2025. On March 31, 2025, at 12:30 p.m., CNS-C stated	01320		

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01320	Continued From page 20 the licensee had not entered ULP-B into the licensee's online training program which resulted in ULP-B not receiving the required orientation, training, or competency testing. CNS-C stated the licensee would need to assign all required orientation and training to ULP-B and then CNS-C would need to perform competency testing for ULP-B. The licensee's Orientation & Training Tracking Form dated June 2021, was provided by CNS-C as licensee's policy for training which indicated multiple topics would be covered but lacked identification of the specific training and competencies ULP-B's record lacked. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or	01330		

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01330	Continued From page 21 (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel ((ULP)-B) had completed training and competency evaluations in all required topics. This had the potential to affect all residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired by the licensee on January 22, 2025. ULP-B's Employee Orientation Checklist was dated by clinical nurse supervisor (CNS)-C on January 15, 2025, (seven days before ULP-B's identified hire date), and lacked documentation ULP-B received any orientation, training, or competency testing. The licensee's March/April Schedule identified by CNS-C as licensee's current and accurate schedule dated March 24, 2025, through April 6, 2025, indicated ULP-B worked directly with residents on March 29, 2025, and March 30,	01330		

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01330	Continued From page 22 2025. On March 31, 2025, at 12:30 p.m., CNS-C stated the licensee had not entered ULP-B into the licensee's online training program which resulted in ULP-B not receiving the required orientation, training, or competency testing. CNS-C stated the licensee would need to assign all required orientation and training to ULP-B and then CNS-C would need to perform competency testing for ULP-B. The licensee's Orientation & Training Tracking Form dated June 2021, was provided by CNS-C as licensee's policy for training which indicated multiple topics would be covered but lacked identification of the specific training and competencies ULP-B's record lacked. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440		

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01440	Continued From page 23 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel ((ULP)-B) were supervised within 30 days of being trained for a delegated a nursing tasks by the clinical nurse supervisor (CNS)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired by the licensee on January 22, 2025. ULP-B's 2.30 Medication Administration - Oral Meds form dated January 15, 2025, (seven days before ULP-B's identified hire date), was signed by CNS-C but lacked documentation ULP-B was trained and found competent to provide	01440		

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01440	Continued From page 24 medication administration to residents. The licensee's March/April Schedule identified by CNS-C as licensee's current and accurate schedule dated March 24, 2025, through April 6, 2025, indicated ULP-B worked directly with residents on March 29, 2025, and March 30, 2025. On March 31, 2025, at 12:30 p.m., CNS-C stated the licensee had trained ULP-B on medication administration but did not complete direct supervision within 30 calendar days. CNS-C stated the licensee would need to retrain ULP-B on medication administration and complete the supervision visit within 30 calendar days. The licensee's 6.17 RN Supervision of Staff - Delegated Services policy dated May 23, 2023, indicated direct supervision of delegated tasks would be completed within 30 calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (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	01470		

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01470	Continued From page 25 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 staff member 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 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	01470		

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01470	Continued From page 26 that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel ((ULP)-B) had completed an orientation in all required topics. This had the potential to affect all residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired by the licensee on January 22, 2025. ULP-B's Employee Orientation Checklist was dated by clinical nurse supervisor (CNS)-C on January 15, 2025, (seven days before ULP-B's identified hire date), and lacked documentation ULP-B received any orientation. The licensee's March/April Schedule identified by CNS-C as licensee's current and accurate	01470		

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01470	Continued From page 27 schedule dated March 24, 2025, through April 6, 2025, indicated ULP-B worked directly with residents on March 29, 2025, and March 30, 2025. On March 31, 2025, at 12:30 p.m., CNS-C stated the licensee had not entered ULP-B into the licensee's online training program which resulted in ULP-B not receiving the required orientation. CNS-C stated the licensee would need to assign all required orientation for ULP-B. The licensee's Orientation & Training Tracking Form dated June 2021, was provided by CNS-C as licensee's policy for training which indicated multiple topics would be covered but lacked identification of the specific orientation ULP-B's record lacked. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	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	01530		

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01530	Continued From page 28 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 provide evidence of dementia care training on required topics for one of two 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired by the licensee on January 22, 2025. ULP-B's Employee Orientation Checklist was dated by clinical nurse supervisor (CNS)-C on January 15, 2025, (seven days before ULP-B's	01530		

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01530	Continued From page 29 identified hire date), and lacked documentation ULP-B received any orientation, training, or competency testing. The licensee's March/April Schedule identified by CNS-C as licensee's current and accurate schedule dated March 24, 2025, through April 6, 2025, indicated ULP-B worked directly with residents on March 29, 2025, and March 30, 2025. On March 31, 2025, at 12:30 p.m., CNS-C stated the licensee had not entered ULP-B into the licensee's online training program which resulted in ULP-B not receiving the required dementia care training. CNS-C stated the licensee would need to assign all required dementia care training for ULP-B to complete. The licensee's 5.03 Dementia Training policy dated May 23, 2022, indicated all direct care employees would complete eight (8) hours of initial dementia care training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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:	01880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 30 Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of one discharged 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 discharged from licensee's services on March 18, 2025. On March 31, 2025, at 11:00 a.m., during a tour of licensee's building, a small refrigerator was noted in the common open concept living and kitchen area. The refrigerator lacked a secured lock and was able to be opened by any person who was in the area. Inside the refrigerator R1's two (2) unused Basaglar insulin pens and four (4) unused Fiasp aspart insulin pens were noted. On April 1, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-C stated when R1 was discharged all other medications were destroyed but the licensee forgot to complete the disposition for the insulin pens in the unsecured fridge. CNS-C stated the licensee was not aware medications in the refrigerator would also need to be secured to prevent unauthorized persons from gaining access to the insulins. CNS-C stated the licensee would obtain a locking mechanism for the refrigerator to ensure all medications that	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38781	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELTER ARM LLC	9444 FALLGOLD PARKWAY NORTH BROOKLYN CENTER, MN 55443

(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 31 required refrigeration would be securely stored. The licensee's 7.11 Medication Storage policy dated May 23, 2022, indicated all medications managed by licensee would be securely stored and per manufacturer's instructions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R3) with transfers and who utilized a side rail. 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).	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38781	A. BUILDING: _____ B. WING _____	04/02/2025

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SHELTER ARM LLC	9444 FALLGOLD PARKWAY NORTH BROOKLYN CENTER, MN 55443

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02310	Continued From page 32 The findings include: BEDRAILS On March 31, 2025, at approximately 11:00 a.m., during facility tour, surveyor observed an installed consumer side rail on one side of R3's bed. R3 was admitted to the licensee on April 29, 2023. R3's registered nurse (RN) assessment dated January 22, 2025, included a side rail assessment. R3's medical record included a completed side rail assessment, but lacked documentation of the following: -the risks and benefits were discussed with the resident/responsible party -the portable side rail has not been recalled by the CPSC; -the portable side rail was installed, used, and maintained per manufacturer's guidelines; and -the manufacturer's guidelines were accessible upon request. On April 1, 2025, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-C stated a risk and benefit discussion was not completed for R3 with consumer side rails, did not check for consumer side rail recalls on the CPSC website, and no manufacturer's guidelines were accessible upon request. CNS-C also stated was unaware of all the requirements on consumer side rails for residents. The licensee's 6.28 Side Rails Policy dated May 23, 2023, indicated when the licensee is aware a resident is utilizing side rails on a bed, the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38781	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 33 licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use of a safe design and utilized consistent with the manufacturer's directions. The FDA's A Guide to Bed Safety dated March 10, 2006, indicated licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. TRANSFERS On April 1, 2025, at 8:55 a.m., observed R3 ambulate with their four wheeled walker (4WW) from the common staircase to the kitchen table without the assistance of staff. When R3 reached the kitchen table, unlicensed personnel (ULP)-D assisted R3 with hand over hand guidance to direct R3 to locate the edge of the table. ULP-D then grabbed R3's sweatpants waistband and assisted R3 to sit at a chair ULP-D positioned for R3 to safely sit. On April 1, 2025, at 9:10 a.m., observed R3 ambulate on own from kitchen table to common living area couch. CNS-C assisted R3 by clearing area on couch for R3 to sit. CNS-C grabbed R3's sweatpants waistband and guided R3 to the space CNS-C had cleared for R3 to sit on the couch. R3's Assessment As Of Date completed by CNS-C on January 1, 2025, read under Mobility - Ambulation, "Wheeled walker Resident need help walking, Uses a walker for short distance with assist of 1 using gait belt (a belt like device	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38781	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 34 placed around a person during ambulation or transfers to allow staff to assist a person safely)." R3's RTasks Ambulation Service document dated April 1, 2025, at 10:01 a.m., read under instructions, "Assist the resident to ambulate daily with Gait belt." R3's Service Recap Summary - Month dated April 2025, was documented by ULP-D as R3's ambulation service was completed as R3 ambulation instructions were written. On April 1, 2025, at 10:10 a.m., CNS-C stated R3 required ambulation assist of 1, but R3 would always refuse the use of the gait belt. CNS-C stated R3 has been approached multiple times by CNS-C and staff to educate on the importance of safe ambulation, but R3 continued to refuse the use of the gait belt. CNS-C stated education would need to be provided to staff to accurately document the service provided and CNS-C would complete a new assessment to address safe ambulation. The licensee's 2.46 Transfer and Ambulation Techniques competency dated May 2021, indicated all standby assist and transfers required a gait belt be placed on a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *03/31/25*
Time: 12:16:25
Report: 1004251068

Food and Beverage Establishment Inspection Report

Location:
Shelter Arm LLC
9444 Fallgold Parkway N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0041265
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders previously issued on 05/30/23 have NOT been corrected.

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 IRREVERSIBLE TEMPERATURE INDICATOR(S) ON SITE TO VERIFY SANITIZING TEMPERATURE OF DISH MACHINE. PROVIDE AND USE FREQUENTLY TO ENSURE A TEMPERATURE OF 160*F OR ABOVE IS REACHED FOR SANITIZING. REISSUED 3/31/25: ONE PROVIDED BY FOLLOWING DAY TO VERIFY.

Issued on: 05/30/23 *Comply By: 05/30/23*

2-100 Supervision

2-102.12AMN

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

NO STATE CERTIFIED FOOD PROTECTION MANAGER. EMPLOYEE HAS TAKEN FOOD SAFETY COURSE BUT DID NOT APPLY WITH THE STATE. INFORMATION PROVIDED TO PERSON IN CHARGE. REISSUED 3/31/25.

Issued on: 05/30/23 *Comply By: 05/30/23*

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.

REFRIGERATOR IS NOT MAINTAINING FOOD TEMPERATURES AT OR BELOW 41*F. ADJUST UNIT AND MAINTAIN.

Issued on: 05/30/23 *Comply By: 06/05/23*

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS FOUND STORED OVER PRODUCE IN THE REFRIGERATOR. ENSURE RAW ANIMAL FOODS ARE STORED BELOW AND SEPARATE FROM READY-TO-EAT ITEMS AND PRODUCE. EGGS WERE MOVED TO THE LOWEST DRAWER DURING INSPECTION.

Comply By: 03/31/25

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

FOOD ITEMS IN THE REFRIGERATOR MEASURED BETWEEN 43-44*F. ENSURE FOOD TEMPERATURES ARE MAINTAINED AT OR BELOW 41*F.

Comply By: 03/31/25

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 SMALL-DIAMETER PROBE THERMOMETER ON SITE. PROVIDE AND USE FOR THIN FOODS.

Comply By: 03/31/25

4-500 Equipment Maintenance and Operation

4-502.11B ***** Priority 2 *****

MN Rule 4626.0820B Calibrate food temperature measuring devices in accordance with manufacturer's specifications as often as necessary to ensure accuracy.

ESTABLISHMENT IS NOT CALIBRATING THEIR FOOD THERMOMETERS. ENSURE THERMOMETERS ARE CALIBRATED/CHECKED FOR ACCURACY ROUTINELY. DISCUSSED CALIBRATION PROCESS WITH PERSON IN CHARGE. INFORMATION PROVIDED WITH REPORT.

Comply By: 03/31/25

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

SOILED DISHES FOUND STORED IN THE BASIN DESIGNATED FOR HANDWASHING. ENSURE HANDWASHING BASIN IS ACCESSIBLE AT ALL TIMES AND ONLY USED FOR HANDWASHING PURPOSES. SOILED DISHES WERE REMOVED DURING INSPECTION.

Comply By: 03/31/25

Type: Full
Date: *03/31/25*
Time: 12:16:25
Report: 1004251068
Shelter Arm LLC

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: TURKEY
Temperature: 43 Degrees Fahrenheit - Location: REFIRGERATOR
Violation Issued: Yes

Process/Item: TURKEY
Temperature: 44 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY BRANDON MUELLER.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE PRESENT ON SITE AND WITH THE NURSE EVALUATOR, BENARD.

*FLOORS ARE SEALED WOOD AND CEILING AND WALLS ARE SMOOTH PAINTED DRYWALL WITH TILE BACKSPLASH.. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. 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.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full
Date: *03/31/25*
Time: 12:16:25
Report: 1004251068
Shelter Arm 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 1004251068 of 03/31/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
ANGIE

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us