Electronically Delivered

February 26, 2025

Licensee
Totalcare Assisted Living Svcs
4301 France Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL32046015

Dear Licensee:

On January 17, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine the correction of orders from the survey completed on August 6, 2024, and follow-up survey completed on November 05, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson

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

JMD

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 11, 2024

Licensee
Totalcare Assisted Living Services
4301 France Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL32046015

Dear Licensee:

On November 5, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 6, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 6, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 6, 2024, found not corrected at the time of the November 5, 2024, follow-up survey and/or subject to penalty assessment are as follows:

1290 - Background Studies Required - 144g.60 Subdivision 1

The details of the violations noted at the time of this follow-up survey completed on November 5, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

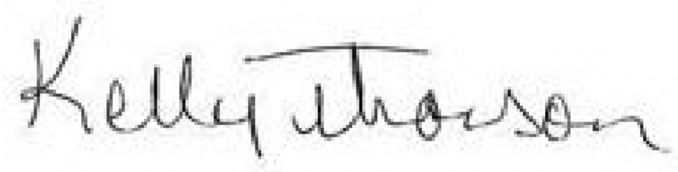
CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and 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

We urge you to review these orders carefully. If you have questions, please contact Kelly Thorson at 320-223-7336.

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,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32046	A. BUILDING: _____ B. WING _____	R 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SVCS	4301 FRANCE AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32046015-1 On November 4, 2024 through November 5, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 7, 2024. At the time of the survey, there were 6 residents; 6 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 660} 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:	{0 660}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	{0 680}		

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{0 680}	Continued From page 2 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	{0 780}		

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{0 780}	Continued From page 3 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	

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{0 810}	Continued From page 4	{0 810}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	

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{0 810}	Continued From page 5	{0 810}		
{01290} SS=E	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 an employee 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 background study (BGS) was submitted and received an affiliation with the assisted living license for two of ten employees (unlicensed personnel (ULP)-F and ULP-G). This had the potential to affect all residents living within 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 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	{01290}		

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{01290}	Continued From page 6 found to be pervasive). The finding include: On November 5, 2024, at 9:00 a.m., the surveyor compared the facility's employee list to the licensee's Minnesota Department of Human Services (DHS) NETStudy 2.0 roster and identified two employees who were not affiliated on the roster for health facility identification numbers (HFID) 32046. ULP-F was hired July 1, 2022, and provided direct care services to residents. ULP-G was hired on August 25, 2023, and provided direct care services to residents. The facility schedule dated October 2024, indicated ULP-F and ULP-G worked multiple afternoon/evening shifts for the licensee during the month of October 2024. On November 5, 2024, at 2:04 p.m., licensed assisted living director (LALD)-D stated both ULP-F and ULP-G worked at another assisted living facility she owns and they are affiliated with the HFID for that license, but they have not been affiliated with the HFID (32046) for this assisted living license. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated the employment process includes the following: -The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: -The director or designee is responsible for initiating the criminal background study for new	{01290}		

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{01290}	Continued From page 7 employees; -NetStudy 2.0 (or current version) will be used for the background check; -The employee will be directed to locations established by DHS to obtain fingerprint scans; -Employees will be instructed that photographic identification will be required; -Employees/ Study subjects may enter their own background study demographic information using the facility identification code provided; and -Results of the background study will be maintained in the employee's personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	{01290}		
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls;	{01370}		

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{01370}	Continued From page 8 (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.	
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident;	{01380}		

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{01380}	Continued From page 9 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}	Not reviewed during this survey.	
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for	{01530}		

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{01530}	Continued From page 10 each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.	
{01820} SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	{01820}	Not reviewed during this survey.	
{02310} SS=F	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:	{02310}	Not reviewed during this survey.	

Electronically Delivered

September 6, 2024

Licensee
TotalCare Assisted Living Services LLC
4301 France Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL32046015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	32046	A. BUILDING: _____ B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SVCS	4301 FRANCE AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32046015-0 On August 5, 2024, through, August 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 6 resident(s); 6 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 6, 2024, issued for SL32046015-0, tag identification 1290. On August 7, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained at an scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated (DATE), for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 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	0 660		

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0 660	Continued From page 2 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 program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes baseline testing for one of two employees licensed practical nurse (LPN)-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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: The facility TB risk assessment was completed July 24, 2024, and indicated the facility was at a low risk for TB transmission. On August 7, 2024, at 9:00a.m., the surveyor observed clinical nurse supervisor (CNS)-A	0 660		

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0 660	Continued From page 3 assisting the residents with meal preparation for breakfast. CNS-A was hired January 20, 2022, to provider direct care services to the licensee's residents and oversight of the licensee's employees. CNS-A's employee record included a negative QuantiFERON TB Gold blood test dated March 25, 2020, greater than 90 days prior to the January 20, 2022, hire date. On August 6, 2024, at 4:00 p.m., CNS-A stated the QuantiFERON gold test in her record was prior to 90 days of her hire and was out of compliance and she did not realize that she could audit her own record so she did not realize the TB test was too old to use. The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, noted, "The purpose of this manual is to assist health care facilities in Minnesota to understand what is needed to be in compliance with Minnesota laws revised in 2013 regarding TB prevention and control, and to provide tools for implementing legal regulations and best practices in their settings." This included, Baseline TB screening is required for all health care workers (HCW). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA; and An employee may begin working with patients after a negative TB symptom screen (i.e., no	0 660		

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0 660	Continued From page 4 symptoms of active TB disease) and a negative IGRA or TST (i.e., frst step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." The licensee's Tuberculosis Screening/Prevention policy, dated August 1, 2021, indicated, "[Licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention and the Minnesota Department of Health. The precautions include the following elements -risk assessment -TB screening; and -staff education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 5 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's emergency preparedness plan (EPP) lacked the required content: - annual review; - develop and maintain the EPP; - missing resident quarterly review; - the development of policies/procedures to address: - subsistence needs for staff and residents;	0 680		

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0 680	Continued From page 6 - use of volunteers; and - roles under a waiver declared by Secretary. - communication plan must include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives. On August 6, 2024, clinical nurse supervisor (CNS)-A stated the annual review sheet was last signed in 2022. CNS-A stated they were not aware the missing person policy needed to be reviewed quarterly. CNS-A agreed some of the required policies are missing from the emergency preparedness binder but they may have them somewhere due to having more than one house but did agree they were not in their emergency preparedness binder. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated will have identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The emergency preparedness plan/program will be reviewed/updated at least annually. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided.	0 680		

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0 680	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate.	0 780		

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0 780	Continued From page 8 This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On August 7, 2024, at 12:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the facility tour, it was observed that smoke alarms immediately outside sleeping rooms on the main and lower levels were not interconnected upon testing, so the actuation of one alarm would cause all alarms to operate. During the interview on August 7, 2024, at 1:00 p.m., ULP-C stated that one type of smoke alarm was installed in resident sleeping rooms, which were interconnected. However, smoke alarms installed in outside sleeping rooms on both levels were of a different type and were not interconnected to the smoke alarms in bedrooms. This deficient condition was verified by ULP-C accompanying the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 9 (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 in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 7, 2024, at 12:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the facility tour, survey staff observed the following items: In the landscape outside the exit door to the backyard on the main level, burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. In the kitchen on the main level, it was observed	0 800		

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0 800	Continued From page 10 that the gypsum ceiling pilaster and paint was bubbled and was peeling off. During the facility tour at 1:00 p.m., ULP-C visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

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0 810	Continued From page 11 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to provide the required 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, 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 August 7, 2024, at 1:30 p.m., the clinical nurse supervisor (CNS)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. The licensed assisted living director (LALD)-D joined the interview over the phone. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute.	0 810		

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0 810	Continued From page 12 Provided documentation indicated that the drills were conducted on 3/1/24, 11/29/23, 9/29/23, and 7/19/23, with no further drills being documented. The provided drills were conducted at 1:00 p.m. or 2 p.m. for the morning shift only. During the interview on August 7, 2024, at 2:00 p.m., LALD-D confirmed that the drills were conducted every three months, and the drills were provided for the morning shift only. LALD-D confirmed there were no documented drills for the afternoon shift and night shift and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	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 an employee 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	01290		

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TOTALCARE ASSISTED LIVING SVCS	4301 FRANCE AVENUE NORTH ROBBINSDALE, MN 55422

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01290	Continued From page 13 licensee failed to ensure a background study (BGS) was submitted and received an affiliation with the assisted living license for one of ten employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents living within the facility. This resulted in an immediate correction order issued on August 6, 2024. 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 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 finding include: On August 6, 2024, at 11:00 a.m., the surveyor compared the facility's employee list to the licensee's Minnesota Department of Human Services (DHS) NETStudy 2.0 roster and identified one employee who was not affiliated on the roster for health facility identification numbers (HFID) 32046 and had an expired COVID-19 study. Further review of ULP-E's individual DHS NetStudy 2.0 affiliations showed ULP-E had been separated from HFID 32046's employment on August 1, 2023, and was reaffiliated on August 6, 2024, after the survey was initiated on August 5, 2024. ULP-E was hired August 19, 2021, and provided direct care services to residents. ULP-E's NETStudy 2.0 roster provided by the	01290		

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01290	Continued From page 14 facility showed the emergency eligibility from COVID-19 had expired. ULP-E's individual NETStudy 2.0 affiliation showed a separation date of August 1, 2023, and a new affiliation date of August 6, 2024. The facility schedule dated August 2024, indicated ULP-E worked the overnight shift on August 1, 2024, and August 5, 2024 and is scheduled to work eight more overnight shifts for the month of August 2024. The Minnesota Department of Human Services website indicated as of July 20, 2023, emergency studies completed during the COVID-19 pandemic were no longer valid. If an individual who was still affiliated had not had a new fingerprint-based background study submitted since their emergency study expired, then the entity is not compliant with state and federal background study requirements. A new fingerprint-based study must be submitted immediately in NETStudy 2.0 for individuals who do not have one. On August 6, 2024, at 11:55 a.m., licensed assisted living director (LALD)-D stated she realized on Monday, August 5, 2024, that ULP-E's background study had not been updated since the COVID-19 eligibility had expired, and updated and affiliated ULP-E's background study with HFID 32046. LALD-D stated ULP-E was a student, which made it difficult to get a hold of them, and had separated from employment with the facility for a while. ULP-E had since returned and worked part-time on the overnight shift, without any supervision. The licensee's Recruitment and Hiring policy	01290		

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01290	Continued From page 15 dated August 1, 2021, indicated the employment process includes the following: -The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: -The director or designee is responsible for initiating the criminal background study for new employees; -NetStudy 2.0 (or current version) will be used for the background check; -The employee will be directed to locations established by DHS to obtain fingerprint scans; -Employees will be instructed that photographic identification will be required; -Employees/ Study subjects may enter their own background study demographic information using the facility identification code provided; and -Results of the background study will be maintained in the employee's personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe	01370		

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01370	Continued From page 16 environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed for two of two employees (unlicensed personnel (ULP)-C and ULP-F). 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	01370		

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01370	Continued From page 17 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 August 7, 2024, at 8:20 a.m., the surveyor observed ULP-C assist a resident with obtaining vitals, blood glucose monitoring and medication administration. ULP-C ULP-C was hired on October 22, 2019, to provide comprehensive home care services and started providing assisted living services on August 1, 2021. ULP-C's employee record lacked documentation of the following required training to be completed by ULP: -medication, exercise, and treatment reminders; -preparation of a modified diets as ordered by a licensed health professional; and -understanding appropriate boundaries between staff and residents and the resident's family. ULP-F ULP-F was hired on July 1, 2022to provide direct care services to residents. ULP-F's employee record lacked documentation of the following required training to be completed by ULP: --reports of changes in the resident's condition to the supervisor designated by the facility; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls;	01370		

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01370	Continued From page 18 -medication, exercise, and treatment reminders; -preparation of a modified diets as ordered by a licensed health professional; and -understanding appropriate boundaries between staff and residents and the resident's family. On August 7, 2024, clinical nurse supervisor (CNS)-A stated she agreed some of the required training topics were missing from the employee records, and she thought she was covering all of the required topics but it is not in their records. The licensee's Staff Competency policy dated August 1, 2021, indicated training and competency evaluations for all unlicensed personnel include the following: - documentation requirements for all services provided; - reports of changes in the residence condition to the supervisor designated by the home care provider; - training on the prevention of falls for providers working with the elderly or those at risk of falls; - medication, exercise and treatment reminders; - basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating; and - understanding appropriate boundaries between staff, residents and the residents family. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

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01380	Continued From page 19 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed for two of two employees (unlicensed personnel (ULP)-C and ULP-F). 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 August 7, 2024, at 8:20 a.m., the surveyor observed ULP-C assist a resident with obtaining vitals, blood glucose monitoring and medication administration.	01380		

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01380	Continued From page 20 ULP-C ULP-C was hired on October 22, 2019, to provide comprehensive home care services and started providing assisted living services on August 1, 2021. ULP-C's employee record lacked documentation of the following required training to be completed by ULP: -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-F ULP-F was hired on July 1, 2022to provide direct care services to residents. ULP-F's employee record lacked documentation of the following required training to be completed by ULP: -observation, reporting, and documenting of resident status; and -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. On August 7, 2024, clinical nurse supervisor (CNS)-A stated she agreed some of the required training topics were missing from the employee records, and she thought she was covering all of the required topics but it is not in their records. The licensee's Staff Competency policy dated	01380		

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01380	Continued From page 21 August 1, 2021, indicated employees may not work for licensee until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following: -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body function, injuries, or other reportable changes; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	01530		

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01530	Continued From page 22 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 observation, interview and record review, the licensee failed to ensure all direct care staff received at least eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for one of one employee unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on October 22, 2019, to provide comprehensive home care services and started providing assisted living services on August 1, 2021. On August 7, 2024, at 8:20 a.m., the surveyor observed ULP-C assist a resident with obtaining vitals, blood glucose monitoring and medication administration.	01530		

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01530	Continued From page 23 ULP-C's employee record indicated ULP-C completed 6.75 hours of initial dementia training, thus did not contain documentation ULP-C completed the required initial eight hours of dementia training, within 160 working hours of ULP-C's employment start date under the assisted living license. On August 7, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-A agreed ULP-C was missing the full 8 hours of initial dementia training and the classes were assigned but the employee must not have completed the classes. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees must have completed at least 8 hours of initial education within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to maintain current medication orders for one of two residents (R2).	01820		

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01820	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on October 26, 2021. R2's diagnosis included type 2 diabetes, alcohol abuse with withdraw delirium, paranoid schizophrenia, bipolar disorder and generalized anxiety disorder. R2's service plan dated March 14, 2023, indicated R2's services included medication administration, behavioral management, socialization, meal preparation, housekeeping, and laundry. R2's medication administration record (MAR) for the month of July 2024, indicated R2 received the following medications: atorvastatin 10 milligrams (mg) for high cholesterol, bupropion HCL 150 mg for depression, bupropion HCL 300 mg for depression, gabapentin 400 mg for diabetic neuropathy, insulin aspart per sliding scale for diabetes, Jardiance 10 mg for diabetes, lamotrigine 25 mg for bipolar disorder, lantus 30 units for diabetes, metformin 500 mg for diabetes, olanzapine 10 mg for schizophrenia, clonidine 0.2 mg for alcohol and drug withdraw,	01820		

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01820	Continued From page 25 fluoxetine 40 mg for depression, mirtazapine 30 mg for depression and methocarbamol 500 mg for muscle spasms. R2's signed physician orders dated February 13, 2024, indicated R2's current medications were: - bupropion 300 mg tablet. Take 1 tablet (300 mg) by mouth every morning; - bupropion 150 mg tablet. Take 1 tablet by mouth every morning; - olanzapine 10mg tablet. Take 1 tablet by mouth every morning; - clonidine 0.2 mg tablet. Take 1 tablet by mouth at bedtime; - fluoxetine 40 mg capsule. Take 2 capsules by mouth at bedtime; - mirtazapine 30 mg tablet. Take 1 tablet by mouth at bedtime; - gabapentin 400 mg capsule. Take 1 capsule by mouth twice daily; - lantus 28 units; and - insulin aspart 100U/ML 15 milliliter (ml). Inject subcutaneously three times daily per sliding scale. R2's records lacked signed physician's orders for the following medications: - lamotrigine 25 mg; - atorvastatin 10 mg; - metformin 500 mg; - Jardiance 10 mg; - lantus 30 units; and - methocarbamol 500 mg. On August 6, 2024, at 2:50 p.m., clinical nurse supervisor (CNS)-A stated that some of the physician orders were faxed from the pharmacy today because they were unable to locate them. CNS-A stated the staff are supposed to upload all new orders in the computer system when they	01820		

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01820	Continued From page 26 are received but some staff are not good at doing this and leave it for other staff members to upload them and there are stacks of orders that need to be uploaded and so they requested the pharmacy to send them today. The licensee's Medication Orders policy dated August 1, 2021, indicated the licensee will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02310 SS=F	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 ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with hospital-style bed rails. 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32046	A. BUILDING: _____ B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SVCS	4301 FRANCE AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 27 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 7, 2024, at 8:20 a.m., the surveyor observed R3's bed rails attached to her hospital bed. R3 was admitted to the licensee on April 4, 2018, and began receiving assisted living services on August 1, 2021. R3's diagnoses include bipolar disorder, anxiety, epilepsy, hypertension and chronic kidney disease. R3's service plan dated January 4, 2024, indicated R3 received assist with transfers, dressing, bathing, medication administration, meal assistance, laundry and housekeeping. R3's Bed Safety Assessment dated June 3, 2024, included: - an assessment; - the rails were FDA compliant; and - the risk vs. benefit were discussed and documented with the resident. R3's assessment lacked: - measurements that were completed and documented. On August 7, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A agreed the bed rail assessment was missing the measurements and the people who came and installed the bed and the bed rails measured them at the time of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32046	A. BUILDING: _____ B. WING _____	08/06/2024

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02310	Continued From page 28 installation but this was not documented in the assessment and she did not realize the specific measurements were required. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32046	A. BUILDING: _____ B. WING _____	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SVCS	4301 FRANCE AVENUE NORTH ROBBINSDALE, MN 55422

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02310	Continued From page 29 each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rail Use policy dated August 1, 2021, indicated the registered nurse (RN) is responsible to ensure that the side rails in use are of a safe design and properly maintained. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *08/06/24*
Time: 11:00:00
Report: 1047241209

Food and Beverage Establishment Inspection Report

Location:
Totalcare Assisted Living Svcs
4301 France Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037621
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632081572
ID #:

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

The following orders were issued during this inspection.

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 EGGS STORED ABOVE READY TO EAT FOOD. RELOCATE EGGS TO LOWER SHELF.

Comply By: 08/06/24

2-100 Supervision

2-103.11DGHI ***** Priority 2 *****

MN Rule 4626.0035DGHIKM The person in charge must ensure employees follow proper food handling procedures, including: effectively wash their hands; prevent cross-contamination of ready-to-eat food with bare hands by using suitable food utensils such as deli tissue, spatulas, tongs, single-use gloves, or proper dispensing equipment; properly cook TCS foods and verify cooking temperatures with a temperature measuring device; properly cool TCS foods that will not be held hot or consumed within 4 hours; maintain TCS foods at proper hot and cold holding temperatures; plumbing cross connection control, and properly sanitize cleaned multiuse equipment and utensils by monitoring the exposure time and concentration of the chemical sanitizing rinse solution, or by monitoring the exposure time and temperature for hot water sanitizing.

OPERATOR DID NOT KNOW FINAL COOKING TEMPERATURES. INFORMATION ON TEMPERATURES WAS PROVIDED & RECOMENDED TO POST ONSITE FOR EVERYONE WORKING IN THE KITCHEN.

Comply By: 08/06/24

4-300 Equipment Numbers and Capacities

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

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

NO SMALL DIAMETER PROBE AVAILABLE ON SITE.

Comply By: 08/13/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETER LOCATED IN BASEMENT REFRIGERATOR TO MEASURE AMBIENT AIR TEMPERATURE IN THE REFRIGERATOR.

Comply By: 08/13/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

WALLS & CABINETS IN THE KITCHEN AND THE FRYER IN THE KITCHEN SHOWED BUILD UP OF GREASE/FOOD DEBRIS.

Comply By: 08/06/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator- yogurt
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: Basement refrigerator
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator S. Remke.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has tiled floor, solid countertop, painted ceiling, FRP walls and solid cabinets.

Type: Full
Date: *08/06/24*
Time: 11:00:00
Report: 1047241209
Totalcare Assisted Living Svcs

Food and Beverage Establishment Inspection Report

A two basin sink is located in the kitchen, along with a separate handwashing sink. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 1047241209 of 08/06/24.

Certified Food Protection Manager: Bridgette Gray

Certification Number: FM112101 Expires: 07/13/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Bridgette Gray
Operator

Signed: _____

Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us