



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

October 8, 2024

Licensee

Dis-Generation Group Inc
6825 46th Avenue North
Brooklyn Center, MN 55428

RE: License Number 417713
Health Facility Identification Number (HFID) 34602
Project Number(s) SL34602015

Dear Licensee:

On September 3, 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 September 3, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective October 8, 2024.

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.

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

Sincerely,

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

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

NOTICE OF EXTENDED CONDITIONAL LICENSE

Electronically Delivered

September 20, 2024

Licensee

Dis-Generation Group Inc

6825 46th Avenue North

Brooklyn Center, MN 55428

RE: Conditional License Number 412623
Health Facility Identification Number (HFID) 34602
Project Number(s) SL34602015

Dear Licensee:

Please note: This letter amends the previous letter dated June 10, 2024. After further review by the department, the fine related to tag 0820 is rescinded. The findings outlined in the State Form for tag 0820 will remain, and compliance with this tag is required to avoid future fines. The timeline has expired for your ability to request a reconsideration or hearing on any other tag or fine.

The Minnesota Department of Health (MDH) completed a follow-up survey on April 23, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results, you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As of April 23, 2024, the condition related to the egress windows imposed on March 14, 2024, was found to be corrected. However, the correction order was re-issued during the follow-up survey in connection to bolt type locks installed on the main floor side of the basement door.

As a result, MDH is extending the conditional license 90-days, due to expire on **September 8, 2024**.

STATE CORRECTION ORDERS

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

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 8, 2024, found not corrected at the time of the April 23, 2024, follow-up survey and/or subject to penalty assessment are as follows:

St - 0 - 0790 - 144g.45 Subd. 2 (a) (2)-(3) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment

St - 0 - 0810 - 144g.45 Subd. 2 (b)-(f) - Fire Protection And Physical Environment

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment

The details of the violations noted at the time of this follow-up survey completed on April 23, 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500,00**. 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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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.

CONDITIONAL LICENSE ISSUED:

MDH will issue Dis-Generation Group Inc an extension to the conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Dis-Generation Group Inc is in substantial compliance.

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

- a. **Deadbolt Lock Requirements:** Dis-Generation Group Inc will replace the locks on the main marked exit door from the facility, as well as the door exiting from the basement. Dis-Generation Group Inc will ensure all exit doors from interior spaces are provided with one security type lock, such as a deadbolt lock, in addition to the door latch lock (two locking devices total), and locks are installed no more than 48 inches from the floor.

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

MDH will determine if Dis-Generation Group Inc is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the extended 90-day conditional license period. If MDH determines Dis-Generation Group Inc is in substantial compliance on the follow up survey, MDH will remove the conditions from Dis-Generation Group Inc's assisted living facility license and Dis-Generation Group Inc will

correct any outstanding violations identified during the survey. If Dis-Generation Group Inc is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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 Tim Hanna, Supervisor, directly at: 507-208-8982.

Sincerely,

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

Rick Michals, J.D.
State Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENDED CONDITIONAL LICENSE

Electronically Delivered

June 10, 2024

Licensee

Dis-Generation Group Inc
6825 46th Avenue North
Brooklyn Center, MN 55428

RE: Conditional License Number 412623
Health Facility Identification Number (HFID) 34602
Project Number(s) SL34602015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on April 23, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results, you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As of April 23, 2024, the condition related to the egress windows imposed on March 14, 2024, was found to be corrected. However, the correction order was re-issued during the follow-up survey in connection to bolt type locks installed on the main floor side of the basement door.

As a result, MDH is extending the conditional license 90-days, due to expire on **September 8, 2024**.

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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.

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REQUESTING A HEARING:

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Sincerely,



Rick Michals, J.D.
State Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/23/2024
NAME OF PROVIDER OR SUPPLIER DIS-GENERATION GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428			
(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: SL34602015-1 On April 22, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 8, 2024, At the time of the survey, there were 2 residents; all receiving services under the Assisted Living license. As a result of the revisit, 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/23/2024
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{0 470}	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action needed.	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/23/2024
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{0 480}	Continued From page 2	{0 480}			
{0 485} SS=C	This MN Requirement is not met as evidenced by: No further action needed. 144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action needed.	{0 485}			
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	{0 510}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/23/2024
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{0 510}	Continued From page 3 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}			
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action needed.	{0 630}			
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 4 include the following information: (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: No further action needed.	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	{0 680}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/23/2024
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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
{0 680}	Continued From page 5 (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: No further action needed.	{0 680}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	{0 790}			

Minnesota Department of Health

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{0 790}	Continued From page 6 failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a 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 a facility tour on April 22, 2024, at 1:35 p.m., with unlicensed personnel (ULP)-B, it was observed that the required fire extinguisher was provided but did not have the required documentation of annual servicing. The manufacture date was observed as 2021 on the extinguisher provided on the main floor and 2022 on the extinguisher in the basement. No documentation was provided for annual service requirements of fire extinguishers. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician.	{0 790}			

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{0 790}	Continued From page 7 During the tour ULP-B, verified the manufacture date stamped on the bottom of the main floor extinguisher was 2021, and the basement extinguisher was 2022. No further information was provided.	{0 790}			
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect more than a limited number of 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{0 800}			

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{0 800}	Continued From page 8 Findings include: On a facility tour on April 22, 2024, at 1:50 p.m., with unlicensed personnel (ULP)-B, the surveyor made the following observations of facility hazards and disrepair: There was a 1 ½ inch trip hazard from a difference in height of the flooring in the hallway near resident room number 4. Floor walking surfaces are required to be maintained free of blunt edges that cause a trip hazard and provide a gradual (sloped) transition. Stains on the ceiling from previous water damage were observed in the basement near the yellow phone on the wall. During a facility tour on April 22, 2024, at 2:00 p.m., ULP-B, verified the above listed observations while accompanying on the tour.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	{0 810}			

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{0 810}	Continued From page 9 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	{0 810}			

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{0 810}	Continued From page 10 During observation on April 22, 2024, at 2:10 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants' accessibility. The plan was located off site at the corporate office. On February 7, 2024, at 11:00 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, 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 FSEP dated December 1, 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan failed to include employee procedures required during a fire or similar emergency specific to this building. The FSEP did not identify specific fire protection actions for residents evident by not providing specific procedures required of residents during a fire or similar emergency in writing in the FSEP. 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 failed to include evacuation status and needs, for each individual resident in	{0 810}			

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{0 810}	Continued From page 11 writing in the plan and available for use during a fire or similar emergency. During a phone interview on April 22, 2024, at 2:15 p.m., LALD/CNS-C, stated the FSEP was not located on site, was at the corporate office and was not provided for review. DRILLS During record review on February 7, 2024, at 11:00 a.m., review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation drills were completed within the last year on April 6, 2023, and October 4, 2023, only. During a phone interview on April 22, 2024, at 2:15 p.m., LALD/CNS-C, stated documentation for drills was not available on site.	{0 810}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	{0 820}			

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{0 820}	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the 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). Findings include: On a facility tour on April 22, 2024, at 1:45 p.m. with unlicensed personnel (ULP)-B, it was observed that a deadbolt lock, door latch lock and sliding barrel bolt type lock were installed on the main marked exit door from the facility creating 3 locking devices. Required exit doors in this type of facility are allowed to be provided with one security type lock (2 locking devices total) such as the deadbolt, in addition to the door latch lock and installed not more than 48 inches from the floor. It was also observed 2-barrel bolt type locks were installed on the main floor side of the basement door preventing exiting from the basement. All doors from interior spaces are required to be openable from the egress side (basement side) for the purpose of exiting during a fire or similar emergency.	{0 820}			

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{0 820}	Continued From page 13	{0 820}			
{0 950} SS=C	TIME PERIOD FOR CORRECTION: Two (2) days. 144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	{0 950}			

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{0 950}	Continued From page 14 No futher action needed.	{0 950}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and	{01060}			

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{01060}	Continued From page 15 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No futher action needed.	{01060}			
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	{01640}			

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{01640}	Continued From page 16	{01640}			
	by: No futher action needed.				
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	{01730}			

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{01730}	Continued From page 17 (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No futher action needed.	{01730}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No futher action needed.	{01760}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

March 14, 2024

Licensee

Dis-Generation Group, Inc.

6825 46th Avenue North

Brooklyn Center, MN 55428

RE: Conditional License Number 412623
Health Facility Identification Number (HFID) 34602
Project Number(s) SL34602015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 8, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on June 12, 2024.

STATE CORRECTION ORDERS

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,000.00. **MDH is not imposing these fines against your license at this time.**

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. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Dis-Generation Group, Inc. a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Dis-Generation Group, Inc. is in substantial compliance.

The following conditions apply:

- a. **Health Facility Construction Permit:** Dis-Generation Group, Inc, will contact The Minnesota Department of Labor and Industry (MNDLI) and obtain a construction permit for a health facility. Within 14-days from the date of this notice, Dis-Generation Group, Inc., will provide MDH with a copy of the permit obtained from MNDLI.
- b. **General Contractor:** Dis-Generation Group, Inc. must provide the following to Casey DeVries (casey.devries@state.mn.us) via email within two (2) weeks of the date of this notice:
 1. Name
 2. License Number
 3. Contract Information
- c. **Egress Window Requirements:** Dis-Generation Group, Inc. will replace at least one window in occupied resident sleeping room #1, and unoccupied resident sleeping rooms #2 and #4 meeting the minimum size requirements. At least one window in each resident bedroom must meet the minimum window opening size of no less than 20 inches in width, with a total of at least 648 square inches (4.5 square feet) required for egress, and have a windowsill height from the floor to the clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width and have a windowsill height from the floor to the clear opening of not more than 48 inches.

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

MDH will determine if Dis-Generation Group, Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Dis-Generation Group, Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions from Dis-Generation Group, Inc.'s assisted living facility license, and Dis-Generation Group, Inc. will correct violations identified during the survey to come into substantial compliance. If MDH determines Dis-Generation Group, Inc. is not in substantial compliance, MDH may take additional enforcement action against Dis-Generation Group, Inc., including placement of additional conditions, issuing an extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

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

Sincerely,

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

Rick Michals, J.D.

Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/08/2024
NAME OF PROVIDER OR SUPPLIER DIS-GENERATION GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428			
(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: SL34602015-0 On February 5, 2024, through February 8, 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 two residents, both of whom received services under the Assisted Living license. An immediate correction order was identified on February 6, 2024, issued for SL34602015-0, tag identification 0820. On February 8, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 470	Continued From page 2 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 February 6, 2024, at 6:50 a.m., R2 stated staff slept on the overnight shifts on the living room couch. R2 stated "they lay on the couch all the time and they are always on the phone which bothers me." On February 6, 2024, at 7:08 a.m., the surveyor inquired how the overnight employees received their rest breaks. Unlicensed personnel (ULP)-D stated before their 30-minute break they would perform a safety check on the residents and during the 30-minute break, they would sleep unless a resident needed assistance. On February 6, 2024, at 7:40 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated ULP were expected to use RTasks (documentation software program) to see assigned duties for the shift and were allowed to take a break, including a 30-minute sleep break, however if it "is a busy night, then we stay awake." On February 6, 2024, at 12:58 p.m., CNS/LALD-C stated overnight ULP took their rest break in the living room chair and if the ULP needed to "nap" it was for 30 minutes however, if the resident needed anything the ULP knew they would need to attend to them because it was "awake overnight" shift. CNS/LALD-C stated their	0 470			

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0 470	Continued From page 3 back up plan was the security camera in the living room and all doors in the facility were kept locked. CNS/LALD-C stated they held a staff meeting where ULP stated they wanted to receive their 30-minute break. CNS/LALD-C stated if they looked at the security camera and they noticed the ULP's eyes were closed it was their break time, but most of the time they were awake. The licensees 2.01 24-Hour Emergency Response policy dated July 26, 2021, indicated resident would have access to 24-hour emergency response by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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	0 480			

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0 480	Continued From page 4 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 February 6, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service;	0 485			

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0 485	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 6, 2024, at 9:10 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C provided the surveyor with a blank contract titled (name of licensee) Assisted Living Contract and stated they used it for all residents who resided at the facility. The licensee's blank assisted living contract page 5 included: "HOUSING RELATED SERVICES INCLUDE IN THE MONTHLY RENT. (name of licensee) includes all basic housing services or amenities identified below in the monthly rent. If Resident purchases or requires additional services after moving in, (name of licensee) will charge an additional fee based on the agreed upon services. Such services are described in Sections III-2 and IV below. Pricing for services not included in rent may be found on the attached pricing sheet. a. Apartment Unit	0 485			

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0 485	Continued From page 6 b. Availability of three (3) nutritious meals per day plus snacks" The licensee's Resident Contract for Assisted Living lacked the option to opt out of the meal plan. On February 6, 2024, at 1:03 p.m., CNS/LALD-C stated the residents do not pay for meals because they received waived services and the resident did not have the option to opt out of the meal plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 an effective infection control program	0 510			

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0 510	Continued From page 7 that complied with accepted health care, medical, and nursing standards for infection control related to gloves, hand hygiene, and sharps disposal. This had the potential to 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 the residents). The findings include: SHARPS On February 5, 2024, at 12:00 p.m., the surveyor observed a plastic food container with a burgundy lid that contained two needles and two syringes. The surveyor did not observe a label on the plastic food container to indicate its use was for sharps disposal. The Food and Drug Administration (FDA) document titled Sharps Disposal Containers in Health Care Facilities dated April 29, 2021, recommended health care facilities use FDA-cleared sharps disposal containers for disposal of used needles and other sharps. The licensee's 8.06 Disposal of Contaminated Materials dated July 26, 2021, indicated a designated sharps container would be used to dispose of needles and syringes. GLOVES/HAND HYGIENE On February 6, 2024, at 7:16 a.m. to 7:50 a.m., the surveyor observed unlicensed personnel	0 510			

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0 510	Continued From page 8 (ULP)-E apply gloves, prepare R2's morning medication, administer R2's morning medication, and return to the computer station to document on R2's medication administration in the computer system. Without glove removal or performing hand hygiene, ULP-E obtained R1's medication bin from the secured medication closet, prepared R1's valproic acid medication, administered the valproic acid to R1, and documented on R1's medication administration in the computer. With out glove removal or performing hand hygiene, ULP-E walked to the refrigerator and touched the meal menu, walked to R2's room, knocked on R2's door to ask R2 if they wanted breakfast, walked to R1's room, knocked on R1's door, and walked back to the computer station and sat down. R2 then asked for breakfast. ULP-E walked to the kitchen, removed gloves, performed hand hygiene, and started to prepare the meal for R2. On February 6, 2024, at 8:00 a.m., ULP-E stated they were trained to wash their hands consistently and to wipe down items with Clorox. The surveyor inquired when a ULP would change gloves. ULP-E stated, "changing times is not specific. When I know I am not satisfied I can change it at any time." ULP-E stated they were trained to change gloves between medication passes. The surveyor inquired why they did not perform hand hygiene between R1 and R2. ULP-E stated R2's medication was a liquid, and they touched the bottom of the medication cup and R1 touched the top of the medication cup. ULP-E stated, "that is why it was ok". On February 6, 2024, at 1:22 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated staff were trained to perform hand hygiene upon the start their shift,	0 510			

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0 510	Continued From page 9 after bathroom use, and when they cooked. CNS/LALD-C stated the staff were trained to wipe down surfaces and knobs every four hours and they were to change their gloves after each task they completed. CNS/LALD-C stated staff forget to take off gloves and have been seen walking around with them on. CNS/LALD-C stated staff stated they kept gloves on because they felt safer and when they noticed this, they provided reeducation and a verbal warning. CNS/LALD-C stated the licensee did have an approved sharps container, and they would dispose of the hard plastic container. The licensee's 8.07 Gloves policy dated July 26, 2021, indicated after gloves were disposed of in the proper receptacle, hand hygiene would need to be performed. The licensee's 8.09 Hand Washing policy dated July 26, 2021, read, "Hand washing shall be completed: - o Before, during, and after preparing food - o Before eating food - o Before and after caring for someone who is sick - o Before and after treating a cut or wound - o After using the toilet - o After changing diapers or cleaning up after someone who has used the toilet - o After blowing your nose, coughing, or sneezing - o After touching an animal or animal waste - o After handling pet food or pet treats - o After touching garbage" The CDC document titled Hand Hygiene Guidance dated January 30, 2020, recommended health care personnel use an alcohol-based hand rub or wash hands with soap and water for the following clinical indications: - immediately before touching a patient;	0 510			

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0 510	Continued From page 10 - before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or the patient's immediate environment; - after contact with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2).	0 630			

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0 630	Continued From page 11 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 widespread 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 R1 diagnosis include bipolar disorder; manic (extreme mood swings that include emotional highs (mania) and lows (depression). R1 service plan Service Plan (Wavier) - Addendum to Contract signed February 5, 2024, indicated R1 received assistance with housekeeping, laundry, meals, socialization, medication management, safety check, and shopping assistance. R1's IAPP dated November 21, 2023, indicated R1 was not at risk to be abused by others however, lacked the following required content: - the person's risk of abusing other vulnerable adults. R2 R2's diagnoses included severe anxiety, severe agitation, mood disorder, depression, traumatic brain injury (TBI), diabetes, sleep apnea, mild intellectual disability, schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior),and hypertension.	0 630			

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NAME OF PROVIDER OR SUPPLIER DIS-GENERATION GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 12 R2's Service Plan (Waiver) - Addendum to Contract signed on February 5, 2024, indicated R2 received assistance with housekeeping, laundry, meals, medication administration, safety check, shopping assistance, snacks, and socialization. R2's IAPP dated February 4, 2024, indicated R2 was not at risk to abuse other vulnerable adults however, lacked the following required content: - the person's risk of being abused by other vulnerable adults. On February 6, 2024, at 1:22 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated the licensee's RTasks (software documenting program) IAPP assessment contained the required content for IAPP, however they did not mark the required content as being assessed. The surveyor observed the CNS/LALD-C updating the IAPP for R1 and R2 to indicate R1 was at risk of abusing other vulnerable adults and R2 was at risk of being abused by other vulnerable adults. The licensees 6.05 Individual Abuse Prevention Plan dated July 26, 2021, read, "1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630			

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0 630	Continued From page 13 days	0 630			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-B, ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

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0 650	Continued From page 14 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 ULP-B was hired on August 16, 2023, to provide direct services to residents. On February 5, 2024, at 9:25 a.m., the surveyor observed ULP-B completing housekeeping tasks around the facility. ULP-B's employee record lacked the following required content: - competency evaluations which include the following: - appropriate and safe techniques in personal hygiene and grooming including hair and bathing, care of teeth, gums, and oral prosthetic devices, care of hearing aids, and dressing and assisting with toileting. On February 8, 2024, at 9:43 a.m., ULP-B stated they received the above competency evaluation by the nurse. ULP-D ULP-D was hired on July 21, 2022, to provide direct services to residents. On February 6, 2024, at 6:48 a.m., the surveyor observed ULP-D was the only staff member in the facility to assist with resident's requests.	0 650			

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0 650	Continued From page 15 ULP-D's employee record lacked the following required content: - competency evaluations which include the following: - appropriate and safe techniques in personal hygiene and grooming including hair and bathing, care of teeth, gums, and oral prosthetic devices, care of hearing aids, and dressing and assisting with toileting. On February 8, 2024, at 11:03 p.m., ULP-D stated they received the competencies evaluations listed above by the registered nurse (RN). ULP-E ULP-E was hired on September 24, 2022, to provide direct services to residents. On February 6, 2024, at 7:35 a.m., the surveyor observed ULP-E administer oral medications to R1. ULP-E's employee record lacked the following required content: - training which include the following: - documentation requirements for all services provided; - reports changes in the residents condition to the supervisor designated; - maintenance of a clean and safe environment; - observation, reporting, and documenting a resident status; - basic knowledge of body functioning and changes in body functioning, injuries or other observed changes that must be reported to appropriate personnel; - competency evaluations which include the following:	0 650			

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0 650	Continued From page 16 - appropriate and safe techniques in personal hygiene and grooming including hair and bathing, care of teeth, gums, and oral prosthetic devices, care of hearing aids, and dressing and assisting with toileting. On February 6, 2024, at approximately 8:00 a.m., ULP-E stated they received the training listed above on EduCare (a training software) and then received a competency evaluation by clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C . On February 6, 2024, at 12:41 p.m., the surveyor inquired if they had any of the competency evaluations listed above. CNS/LALD-C stated they had not filled them out, but they had them in back. The surveyor observed CNS/LALD-C take out a stack of papers that contained at minimum 20 sheets of paper and stated, "these are the one I have to complete." The surveyor requested to observe the stack of papers and observed competencies with names written on them, however, the documents were not signed or marked with pass or fail. The surveyor inquired why there were not in the employee record or completed. CNS/LALD-C stated they were the ones they had not finished signing and some ULP did not pass the first time, so they had to retake the test again. On February 6, 2024, at 12:50 p.m., the surveyor inquired if the competencies not filled out were completed with the ULP. CNS/LALD-C stated yes but they just did not complete the paperwork. On February 6, 2024, at 1:04 p.m., CNS/LALD-C stated they used EduCare to train the ULP and then completed competency evaluations provided by the EduCare system on each required topic.	0 650			

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0 650	Continued From page 17 The surveyor inquired why the competency evaluations listed above were not complete. CNS/LALD-C stated, "I have no reason, I am just delayed." The licensee's 4.05 Employee Records policy dated July 26, 2021, indicated employee record for each person would include records of all training and in-service education required and/or provided including a record of competency testing as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680			

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0 680	Continued From page 18 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 residents of the assisted living 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual review; - hazard vulnerability risk assessment; - emerging infectious diseases; - documented risk assessment; - strategies for addressing facility and community-based risks; - missing resident plan; - EP patient population; - process for EP collaboration; - subsistence needs for staff and residents;	0 680			

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0 680	Continued From page 19 - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - development of communication plan; - names and contact information; - emergency official contact information; - primary and alternative means for communication; - methods for sharing information; - sharing information on occupancy and needs; - long-term care (LTC) family notifications; and - emergency preparation and testing requirements. On February 6, 2024, at 1:34 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they completed an emergency preparedness drill in April with the police, however, was unable to provide documentation of the drill. CNS/LALD-C stated, they are aware of the requirements, but had not completed all of the required contents for Appendix Z. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated October 15, 2021, the licensee would include all required elements of appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 790	Continued From page 20	0 790			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a 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 a facility tour on February 6, 2024, at 10:15 a.m., with licensed clinical nurse supervisor/assisted living director (CNS/LALD)-C, it was observed that the required fire extinguisher	0 790			

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0 790	Continued From page 21 was provided but did not have the required documentation of annual servicing. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on February 7, 2024, at 11:15 a.m., CNS/LALD-C, stated the fire extinguisher was purchased at a hardware store and they did not know the manufacture date needed to be updated or the extinguisher needed to be serviced annually. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

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0 800	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on February 6, 2024, at 10:20 a.m., with licensed clinical nurse supervisor/assisted living director (CNS/LALD)-C, the surveyor made the following observations of facility hazards and disrepair: There was a 1 ½ inch trip hazard from a difference in height of the flooring in the hallway near resident room number 4. Floor walking surfaces are required to be maintained free of blunt edges that cause a trip hazard. A plastic container was observed outside on a concrete patio with discarded cigarette butts in it. There was also a black plastic garbage bag next to the plastic container that had cigarette butts in it as well. Both the plastic container and the black plastic garbage bag were near the exterior wall of the building. Used smoking materials are required to be disposed of in appropriate containers	0 800			

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0 800	Continued From page 23 designated for disposal of used smoking materials. Stains on the ceiling from previous water damage were observed in the basement near the yellow phone on the wall. During a facility tour on February 6, 2024, at 10:25 a.m., CNS/LALD-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) 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	0 810			

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0 810	Continued From page 24 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide 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 February 7, 2024, at 11:00 a.m., licensed clinical nurse supervisor/assisted living director (CNS/LALD)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810			

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0 810	Continued From page 25 FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated December 1, 2022, failed to include the following: The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan failed to include employee procedures required during a fire or similar emergency specific to this building. The FSEP did not identify specific fire protection actions for residents evident by not providing specific procedures required of residents during a fire or similar emergency in writing in the FSEP. 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 failed to include evacuation status and needs, for each individual resident in writing in the plan and available for use during a fire or similar emergency. During an interview on February 7, 2024, at 11:25 a.m., CNS/LALD-C stated the employee and resident procedures required during a fire or similar emergency were not included in writing in the FSEP. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing	0 810			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/08/2024
NAME OF PROVIDER OR SUPPLIER DIS-GENERATION GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 26 documentation drills were completed within the last year on April 6, 2023, and October 4, 2023, only. During an interview on February 7, 2024, at 11:45 a.m., CNS/LALD-C stated documentation drills were completed was only available for April 6, 2023, and October 4, 2023, and not for the remainder of the year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. This practice resulted in a level three violation (a	0 820	This immediate correction order identified on February 6, 2024, has had the immediacy lifted as of February 8, 2024, however non-compliance remained a scope and level of I.		

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0 820	Continued From page 27 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). Findings include: On a facility tour on February 6, 2024, at 10:45 a.m. with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms number 1, number 2, and number 4. Occupied Resident Rooms Resident sleeping room number 1 occupied by R1, emergency escape and rescue clear window opening measurements are 28.5 inches wide, 14.5 inches in height and 413 square inches in openable area. The window was measured with CNS/LALD-C, and survey staff present. The window did not meet the minimum requirements for clear opening width and minimum clear opening area. Unoccupied Room Resident sleeping room 2, emergency escape and rescue clear window opening measurements are 28.5 inches wide, 14.5 inches in height and 413 square inches in openable area. The window was measured with CNS/LALD-C, and survey staff present. The window did not meet the minimum requirements for clear opening width	0 820			

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0 820	Continued From page 28 and minimum clear opening area. Resident sleeping room 4, emergency escape and rescue clear window opening measurements are 34.5 inches wide, 16.5 inches in height and 569 square inches in openable area. The window was measured with CNS/LALD-C, and survey staff present. The window did not meet the minimum requirements for clear opening width and minimum clear opening area. It was explained to CNS-LALD-C that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. And have a windowsill height from the floor to the clear opening of not more than 48 inches. These deficient conditions were visually verified by CNS/LALD-C accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate	0 820			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:	0 950			

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0 950	Continued From page 29 "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include verbatim language giving residents the right to identify a designated representative for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	0 950			

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0 950	Continued From page 30 The findings include: R1 R1 admitted to the licensee on November 7, 2023, and began receiving assisted living services. R2 R2 admitted to the licensee on November 1, 2023, and began receiving assisted living services. R1 and R2's Assisted living Contract were signed on November 7, 2023, and November 1, 2023, respectively, and included statute statements from 144.50 subd. 3., on page 18. The contracts lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On February 6, 2024, at 1:34 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were unaware of the requirement for the contract. The licensee's 1.08 Designated Representative policy dated July 26, 2021, stated, "Before or at the time of execution of an assisted living contract, (licensee name), Inc will offer residents the opportunity to identify a designated representative in writing." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			

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01060	Continued From page 31	01060			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060			

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01060	Continued From page 32 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for a resident's emergency relocation to the resident, legal representative, or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 service plan Service Plan (Wavier) - Addendum to Contract signed February 5, 2024, indicated R1 received assistance with housekeeping, laundry, meals, socialization, medication management, safety check, and shopping assistance. R1s Progress Notes dated January 10, 2024, through February 5, 2024, indicated on January 17, 2024, R1 was taken to the hospital for	01060			

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01060	Continued From page 33 aggressive behaviors and returned to the licensee on January 31, 2024. R1's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On February 6, 2024, at 1:34 p.m., clinical nurse supervisor (CNS/LALD)-C stated they were unsure what an emergency relocation notification was, and OOLTC was given notification, however, they did not document it. The surveyor inquired if they licensee had ever provided an emergency relocation notice to any resident hospitalized. CNS/LALD-C stated no, "this is new to me." The licensee's 1.23 Emergency Relocation policy dated June 26, 2021, indicated in the event of an emergency relocation, the licensee "would provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. The facility will provide contact information for	01060			

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01060	Continued From page 34 the agency to which the resident may submit an appeal. 4. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. 5. Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the contract termination process." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640			

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01640	Continued From page 35 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on November 7, 2023, and began receiving assisted living services. R1 Service Plan (Wavier) - Addendum to Contract signed February 5, 2024, indicated R1 received assistance with housekeeping, laundry,	01640			

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01640	Continued From page 36 meals, socialization, medication management, safety check, and shopping assistance. The service plan was signed during the survey. On February 6, 2024, at 7:35 a.m., the surveyor observed ULP-E administer oral medications to R1. R2 R2 admitted to the licensee on November 1, 2023, and began receiving assisted living services. R2's Service Plan (Waiver) - Addendum to Contract signed on February 5, 2024, indicated R2 received assistance with housekeeping, laundry, meals, medication administration, safety check, shopping assistance, snacks, and socialization. The service plan was signed during the survey. On February 6, 2024, at 7:44 a.m., the surveyor observed ULP-E administer oral medications to R2. R1 and R2's service plans lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided completed prior to the survey. On February 6, 2024, at 12:03 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated R2 previously refused to sign the service plan and they had been reapproaching R2 to sign the document "little by little". CNS/LALD-C stated R1's representative signed the Rate Input Report for the state however, they forgot to print off the service plan from RTasks (a documenting software program)	01640			

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01640	Continued From page 37 to sign. The surveyor inquired if they had documentation of R2's refusal to sign the service plan. CNS/LALD-C stated no. On February 6, 2024, at 1:44 p.m., CNS/LALD-C stated service plans were developed with the community access for disability inclusion (CADI) case worker and the licensee and then explained to the resident or resident representative. CNS/LALD-C stated after the service plan was explained they would have the resident or resident representative sign the service plan. CNS/LALD-C stated the service plan should be signed on the date of admission. The licensee's 6.08 Service Plan policy dated July 26, 2021, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident or resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730			

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01730	Continued From page 38 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R2).	01730			

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01730	Continued From page 39 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 widespread 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 R1 admitted to the licensee on November 7, 2023, and began receiving assisted living services. R1's diagnosis included bipolar disorder; manic (extreme mood swings that include emotional highs (mania) and lows (depression)). R1's service plan Service Plan (Wavier) - Addendum to Contract signed February 5, 2024, indicated R1 received assistance with housekeeping, laundry, meals, socialization, medication management, safety check, and shopping assistance. On February 6, 2024, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-E administer oral medications to R1. R1's 14-day nursing assessment and Individualized Medication Management Plan dated November 21, 2023, indicated R1 needed full medication management, secured storage of all medications, staff were to contact the nurse by phone if a medication concern arose, ear drops were a delegated task to the ULP, and staff were	01730			

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01730	Continued From page 40 to stay with R1 until medications were swallowed. The documents did not reflect whether the ULP would administer oral medications to R1. R1's electronic medication administration record titled Med Admin Summary-Month dated February 1, 2024, through February 29, 2024, included quetiapine fumarate 50 milligrams (mg) give 50 to 100 mg by mouth four times per day as needed (PRN) for anxiety or sleep. The EMAR lacked specific resident instructions on when R1 would receive 50 mg vs 100 mg of quetiapine fumarate. R1's medication management plan comprised of multiple documents lacked the following: - specific written instructions for resident medication administration; and - medication management tasks that may be delegated to ULP. R2 R2 admitted to the licensee on November 1, 2023, and began receiving assisted living services. R2's diagnoses included severe anxiety, severe agitation, mood disorder, depression, traumatic brain injury (TBI), diabetes, sleep apnea, mild intellectual disability, schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), and hypertension. R2's Service Plan (Waiver) - Addendum to Contract signed on February 5, 2024, indicated R2 received assistance with housekeeping, laundry, meals, medication administration, safety check, shopping assistance, snacks, and socialization.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/08/2024
NAME OF PROVIDER OR SUPPLIER DIS-GENERATION GROUP INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428			
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01730	Continued From page 41 On February 6, 2024, at 7:44 a.m., the surveyor observed ULP-E administer oral medications to R2. R2's 14-day nursing assessment completed on November 15, 2023, and Individualized Medication Management Plan dated February 4, 2024, indicated R2 needed full medication management, medications were kept secure, inhalers were a delegated task to the ULP, staff were to contact the nurse by phone if a medication concern arose, and staff were to stay with R2 until medications were swallowed. The documents did not reflect whether the ULP would administer oral medications to R2. R2's medication management plan comprised of multiple documents lacked the following: - medication management tasks that may be delegated to ULP. On February 6, 2024, at 1:47 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they attempted to receive parameters for quetiapine fumarate since R1's admission from the provider however, the provider had not responded. CNS/LALD-C stated for medication management tasks that may be delegated to the ULP for R1 and R2, they accidentally did not mark oral medication in RTasks (a documenting software program). The licensee's 7.03 Medication Management Individualized Plan dated July 26, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: -a statement describing the medication	01730			

Minnesota Department of Health

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01730	Continued From page 42 management services that will be provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760			

Minnesota Department of Health

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01760	Continued From page 43 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider orders for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2's diagnoses included severe anxiety, severe agitation, mood disorder, depression, traumatic brain injury (TBI), diabetes, sleep apnea, mild intellectual disability, schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), and hypertension. R2's Service Plan (Waiver) - Addendum to Contract signed on February 5, 2024, indicated R2 received assistance with housekeeping, laundry, meals, medication administration, safety check, shopping assistance, snacks, and socialization.	01760			

Minnesota Department of Health

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01760	Continued From page 44 R2's prescriber order dated October 15, 2023, included Nurtec 75 milligrams (mg) every other day to help with migraine prevention. On February 6, 2024, at 7:16 a.m., the surveyor observed ULP-E obtain R2's medications from the medication closet. ULP-E verified aspirin 81 mg, escitalopram 10 mg, escitalopram 20 mg, ferrous sulfate 325 mg, fiber lax one tablet, hydroxyzine 25 mg, lisinopril 2.5 mg, meclizine 25 mg, methenamine hippurate 1 gram (g), olanzapine 15 mg, risperidone 0.5 mg, spironolactone 25 mg, trospium chloride 20 mg, Symbicort inhaler 160-4.5 microgram (mcg), and two tablets of vitamin B-12 1000 mcg against the electronic medication administration record (EMAR), and walked the medication to R2 in the living room. R2 requested the medication Nurtec. ULP-E administered the medications listed above to R2. ULP-E inquired to R2 the last time they received Nurtec. R2 stated "yesterday" ULP-E retrieved Nurtec 75 mg, placed medication into the medication cup, and administered the medication to R2. ULP-E returned to the computer and marked complete at the bottom of the EMAR signifying all morning medications were administered. The surveyor did not observe Nurtec on the list of medication in the EMAR. The surveyor inquired where the ULP would document the administration of Nurtec. ULP-E stated the medication was a PRN (as needed) medication and "I don't think it is here. We can give it to her after one day." The surveyor did not observe ULP-E verify Nurtec against the EMAR which lead to a medication error related to Nurtec being administered a day early. R2's Med Admin Summary - Month indicated R2 received Nurtec 75 mg every other day for	01760			

Minnesota Department of Health

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01760	Continued From page 45 migraine prevention. In addition, R2 received Nurtec on Monday February 5, 2024, and R2's next dose was schedule to be administered on February 7, 2024. On February 6, 2024, at 7:53 a.m., ULP-E stated they were trained on medication administration by clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C. ULP-E stated CNS/LALD-C trained them to obtain the medication, go through the medication one at a time, and make sure medications matched the EMAR. The surveyor inquired how they were trained to provide PRN medications. ULP-E stated if a resident requested medication or if a resident was experienced a specific symptom, they would provide the resident with a prn medication to relieve the symptom and document the medication administration. The surveyor inquired why ULP-E did not document administration of Nurtec. ULP-E stated R2 admitted with Nurtec however, there was nothing in the EMAR to indicate R2 could take the Nurtec and R2 had been requesting Nurtec every other day since admission. ULP-E stated CNS/LALD-C was aware that the ULP-E could not document on Nurtec. The surveyor inquired how another ULP would know that Nurtec was given. ULP-E stated they might document administration in a progress note or they would update the next ULP at shift report. On January 6, 2024, at 1:50 p.m., CNS/LALD-C stated ULP were trained to wash their hands, obtain medication, verify the medication by the shape, color, and number on the pill against the EMAR three times, and if they have any question related to the medications, they should call a nurse. CNS/LALD-C stated Nurtec was a scheduled medication for R2 and would be	01760			

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01760	Continued From page 46 scheduled on specific days on the EMAR for ULP to administer. CNS/LALD-C verified that Nurtec was scheduled on the EMAR to be administered on February 7, 2024. The licensee's Medication Administration Policy dated October 1, 2021, indicated the staff who administered medication would check the medication in the computer and verify medication with shape and color. In addition, staff would follow the following six rights of medication administration: right resident, right medication, right time and day, right dose, right route, and right resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			



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

Type: Full
Date: 02/06/24
Time: 10:05:00
Report: 1043241013

Food and Beverage Establishment Inspection Report

Page 1

Location:

Dis-Generation Group Inc
6825 46th Avenue North
Crystal, MN 55428
Hennepin County, 27

Establishment Info:

ID #: 0038981
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634329130
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.

3-500C Microbial Control: date marking

3-501.17B

**** Priority 2 ****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

NO DATE MARK OBSERVED ON OPEN BAG OF CHEESE IN REACH-IN COOLER. ADVISED STAFF TO PROVIDE DATE MARK AND DISCARD ANY LEFTOVERS AFTER 7 DAYS OF OPENING PACKAGES FOR TCS FOODS. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 02/06/24

4-300 Equipment Numbers and Capacities

4-302.13B

**** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

FACILITY HAS A RESIDENTIAL DISH MACHINE. STAFF WAS UNABLE TO LOCATE TEST KIT. ADVISED STAFF TO LOCATE/REPURCHASE THERMOMETER OR THERMOLABELS. UTENSIL SURFACE TEMPERATURE SHOULD MEASURE AT LEAST 150F FOR ANSI 184. COMPLY WITH ABOVE RULE.

Comply By: 02/06/24

Type: Full
Date: 02/06/24
Time: 10:05:00
Report: 1043241013
Dis-Generation Group Inc

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
FACILITY DOES NOT HAVE A CFPM. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.
Comply By: 02/06/24

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 38 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 38 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

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

Discussed date marking, illness policy, sanitizer use, ware washing, temperature control, hand washing, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Inspection was completed with S. Iwchukwu. A. Crews was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

Utensil surface temperature result from dish machine was provided by staff via email after the inspection was conducted.

****Foods cooked by the facility staff for clients should be fully cooked and prepared for same day service only with leftovers discarded.**

****This facility has a residential kitchen with residential equipment and wooden cabinetry. The kitchen finishes and surfaces are well maintained. Contact Health Regulation Division for plan review when facility undergoes remodeling.**

*****If any customer complains of illness, establishment is required to notify the Minnesota department of health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455*****

Type: Full
Date: 02/06/24
Time: 10:05:00
Report: 1043241013
Dis-Generation Group Inc

Food and Beverage Establishment Inspection Report

Page 3

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 1043241013 of 02/06/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Stella Iwchukwu
PIC

Signed: _____

Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us