Electronically Delivered

April 23, 2025

Licensee
Project Caring
14410 21st Street North
Stillwater, MN 55082

RE: Project Number(s) SL30698016

Dear Licensee:

On March 27, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 15, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 15, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 15, 2025, found not corrected at the time of the March 27, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on March 27, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

We urge you to review these orders carefully. If you have questions, please contact Renee Anderson at 651-201-5871.

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,

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30698	A. BUILDING: _____ B. WING _____	R 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROJECT CARING	14410 21ST STREET NORTH STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#30698016-1 On March 26, 2025 through March 27, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 15, 2025. At the time of the survey, there were nine residents; nine receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}		

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this follow up survey.	
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}	Not reviewed during this follow up survey.	
{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	{0 790}		

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{0 790}	Continued From page 3 Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this follow up survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	{0 810}		

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{0 810}	Continued From page 4 not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this follow up survey.	
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract.	{0 900}		

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{0 900}	Continued From page 5 Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}	Not reviewed during this follow up survey.	
{01020} SS=D	144G.52 Subd. 5 Expedited termination (a) A facility may initiate an expedited termination of housing or services if: (1) the resident has engaged in conduct that substantially interferes with the rights, health, or safety of other residents; (2) the resident has engaged in conduct that substantially and intentionally interferes with the safety or physical health of facility staff; or (3) the resident has committed an act listed in section 504B.171 that substantially interferes with the rights, health, or safety of other residents. (b) A facility may initiate an expedited termination of services if: (1) the resident has engaged in conduct that substantially interferes with the resident's health or safety; (2) the resident's assessed needs exceed the scope of services agreed upon in the assisted living contract and are not included in the services the facility disclosed in the uniform checklist; or (3) extraordinary circumstances exist, causing the facility to be unable to provide the resident with the services disclosed in the uniform checklist that are necessary to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01020}	Not reviewed during this follow up survey.	

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{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to obtain a cleared Department of Health and Human Services (DHS) background study, associated with the licensee's health facility identification number (HFID) for one of eight unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired April 21, 2020, and provided	{01290}		

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{01290}	Continued From page 7 direct cares services to the residents. ULP-C's employee record contained documentation of a cleared DHS background study dated April 10, 2020, however, the background study had been submitted through the providers previous license, HFID 26164. ULP-C's employee record lacked evidence the licensee ensured a cleared background study was obtained, affiliated with the surveyed assisted living license, HFID 30698. On March 27, 2025, at 8:03 a.m., licensed assisted living director (LALD-A) provided, via email, the licensee's current Net Study 2.0 roster. LALD-A stated, via email, "I ran background checks for 3 new employees yesterday. They are training and under supervision. I highlighted these employees in yellow. I didn't catch this before, but I had one employee who was cleared under my previous license. She's my longest employee but I never saw that she wasn't on my updated roster. She works supervised during the daytime. I ran hers yesterday as well. She is highlighted in Blue." The licensee's employee schedule for March 2025, indicated ULP-C was the only ULP scheduled to work at the following times: -7:00 a.m. to 8:00 a.m., on March 1, 5, 8, 9, 11, 13, 14, 22, 23, 27, and 28; -3:30 p.m. to 4:00 p.m., on March 10, and 24; and -7:00 p.m. to 8:00 p.m., on March 12, and 18. On March 27, 2025, at 10:14 a.m., LALD-A stated, via phone, he agreed the licensee's previous HFID 26164 Net Study roster was disabled. LALD-A stated he was not sure why he missed affiliating ULP-C to the current license HFID 30698. Also, LALD-A verbalized he initiated	{01290}		

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{01290}	Continued From page 8 the affiliation background study process for ULP-C on March 26, 2025, during the survey. Finally, LALD-A stated he needed to further change his process on background studies and planned to update the background study policy. The licensee's Background Check policy dated February 1, 2025, indicated, "At [Licensee] it is mandatory for all employees to pass the state-required background check prior to working any shift unsupervised." In addition, included, under the section titled Procedure: -All prospective employees must undergo a state-required background check as part of the hiring process; -The background check will be conducted by an authorized agency and will include, but not be limited to, criminal history, employment verification, and reference checks. -Only those who have successfully passed the background check will be permitted to work any shift unsupervised. -Employees who do not pass the background check will be subject to further review and possible termination of employment." -Periodic background checks may be conducted at the discretion of [licensee] to ensure ongoing compliance with this policy. Finally, under the section titled Responsibilities: -Human Resources Department: Responsible for coordinating background checks and ensuring compliance with this policy. -Supervisors: Ensure that all employees working unsupervised have passed the required background check. No further information was provided.	{01290}		

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{01890}	Continued From page 9	{01890}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this follow up survey.	

Electronically Delivered

February 20, 2025

Licensee
Project Caring
14410 21st Street North
Stillwater, MN 55082

RE: Project Number(s) SL30698016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

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PROJECT CARING	14410 21ST STREET NORTH STILLWATER, MN 55082

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30698016 On January 13, 2025, through January 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were nine residents; nine receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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	30698	A. BUILDING: _____ B. WING _____	01/15/2025

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 13, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 14, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed. The sprinkler system lacked a tag at the riser indicating the last time the sprinkler system was serviced. LALD-A stated that they thought that they believed they system was serviced at the	0 775		

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0 775	Continued From page 4 time of the last survey. Water-based automatic fire extinguishing systems shall be inspected and tested annually. The internally lighted exit sign located in the lower level leading to the back yard would not stay lit when the battery back up was tested. LALD-A stated that the battery was probably dead because the exit sign is wired through a light switch and gets shut off when the lights in the area are turned off. The power supply for means of egress illumination shall normally be provided by the premise's electrical supply. The emergency power system shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
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	0 790		

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0 790	Continued From page 5 by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 14, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A. The portable fire extinguishers throughout the facility lacked records to show the required annual certification was completed. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. On January 14, 2025, the surveyor explained to LALD-A that the portable fire extinguishers must be provided annual certification tags and monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated	0 790		

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0 790	Continued From page 6 location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	0 810		

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0 810	Continued From page 7 not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 14, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire guidance", undated, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810		

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0 810	Continued From page 8 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. No documentation was provided. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. No documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.	0 900		

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0 900	Continued From page 9 (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract containing a signature or other authentication by the facility and by the resident prior to providing assisted living services 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	0 900		

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0 900	Continued From page 10 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 was admitted on December 27, 2024. R2's medical record included a signed "Service Plan (Waiver) - Addendum to Contract," dated December 27, 2024. The service plan indicated R2 received services including assistance with housekeeping, laundry, dressing, grooming, bathing, mobility, blood glucose monitoring, and medication administration. On January 14, 2025, at 12:08 p.m., the surveyor observed unlicensed personnel (ULP)-D assist R2 with blood glucose monitoring and medication administration. R2's medical record included a Resident Agreement dated January 13, 2025, completed at the time of survey. The contract was signed by the licensee but lacked a signature or other authentication by the resident or resident's representative. R2's record lacked a contract signed by both the licensee and the resident or the resident's representative, before providing services. On January 13, 2025, at 11:57 a.m., licensed assisted living director (LALD)-A stated R2's contract had not been completed yet or signed by the resident, resident's representative, or facility representative. LALD-A further stated things got away from him over the holidays and had not	0 900		

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0 900	Continued From page 11 completed R2's contract yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01020 SS=D	144G.52 Subd. 5 Expedited termination (a) A facility may initiate an expedited termination of housing or services if: (1) the resident has engaged in conduct that substantially interferes with the rights, health, or safety of other residents; (2) the resident has engaged in conduct that substantially and intentionally interferes with the safety or physical health of facility staff; or (3) the resident has committed an act listed in section 504B.171 that substantially interferes with the rights, health, or safety of other residents. (b) A facility may initiate an expedited termination of services if: (1) the resident has engaged in conduct that substantially interferes with the resident's health or safety; (2) the resident's assessed needs exceed the scope of services agreed upon in the assisted living contract and are not included in the services the facility disclosed in the uniform checklist; or (3) extraordinary circumstances exist, causing the facility to be unable to provide the resident with the services disclosed in the uniform checklist that are necessary to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to properly initiate expedited	01020		

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01020	Continued From page 12 termination of an Assisted Living Contract for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on December 13, 2023, and had diagnoses including malignant tumor of prostate, type two diabetes (a problem in the way the body regulates and uses sugar as a fuel), and obstructive and reflux uropathy (an obstructed flow of urine). R1's Resident Profile indicated R1 received services from licensee to include assistance with bathing, mobility, dressing, toileting, safety checks and medication administration. R1's medical record included four pages of progress notes dated January 3, 2024, through April 16, 2024, included the following nurse's notes of concerns with R2: -April 13, 2024, at 2:30 p.m., change of condition note, "Resident is unable to bear weight, he is very weak and unable to safely transfer out of bed. Hospice is aware and stated that we can send him out for respite care at the hospital if needed. Nurse has attempted to call [family] 3 times and message sent out since this morning around 11am with no response. HHA is stating that resident can hardly move around in bed and	01020		

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01020	Continued From page 13 knees are unable to bend. This is unsafe for staff and resident. On-call [nurse] will call paramedics to transfer to [hospital] for immediate respite care and update hospice. Will update [family] when we hear back from her." -April 13, 2024, at 3:01 p.m., "Notified 911 for transport to [hospital] for respite stay due to increased care needs that residential facility unable to meet due to safety concerns." -April 13, 2024, at 3:21 p.m., "[family] called nurse back. Informed daughter of plan to send to [hospital] for Respite care due to change of condition and safety. Daughter agrees and is aware." -April 13, 2024, at 4:30 p.m., "Residents is refusing to leave via paramedics. He is stating that he is fully able to get up on his own and does not understand why 2 staff members cannot help lift him. Nurse explained multiple times that we are not licensed to be a lift facility and all of our residents have to be a 1 assist transfer. Every HHA on staff today has said he is unable to safely bear weight. Resident and daughter were made fully aware that if his mobility declined he would no longer be able to stay with us and would have to be sent out. Resident does not agree and is refusing to leave. Nurse reiterated that he cannot stay with his current condition that it is against our policy and is unsafe for both staff and himself. Nurse informed [daughter] and she will be heading that way to talk to him and help get him transported to the hospital." On April 13, 2024, at 5:50 p.m., R1 was discharged from the licensee and brought to the hospital via the emergency medical system (EMS). R1's Discharge/Transfer Summary dated April 16,	01020		

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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
01020	Continued From page 14 2024, indicated under current status, "Current behavioral status: Resident was refusing to leave via paramedics, resident was no longer a 1 assist transfer and could not weight bear. Resident and family were aware upon re-admission that resident needed to be a 1 assist transfer. Resident eventually left via paramedics however refused for 3 hours." In addition, discharge/transfer reason included, "Resident's condition was declining, resident was unable to stay with us until finding placement due to declined mobility and being unable to bear weight. Resident is discharging to [hospital] for respite care until he can get into placement at a skilled nursing facility to continue hospice. Resident was no longer a 1 assist transfer and could not weight bear. Resident and family were aware upon readmission that resident needed to be a 1 assist transfer." On January 14, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-B stated R1 had a change in condition and the licensee was no longer able to care for him due to R1 no longer a one-person transfer. The surveyor requested a copy of the progress notes, termination notice, and notifications provided to R1 or R1's representative. On January 15, 2025, at 10:55 a.m., licensed assisted living director (LALD)-A stated, via phone, he was not aware the licensee should have followed an expedited termination process with R1. Also, LALD-A stated the licensee had the expedited termination and emergency relocation forms but failed to use them with R1's situation. Additionally, LALD-A verbalized he had not notified the Office of Ombudsman for Long-Term Care (OOLTC). Finally, LALD-A stated he planned to talk with CNS-B and ensure they	01020		

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01020	Continued From page 15 follow the appropriate process and notifications going forward. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 13, 2025, indicated under Mobility Services licensee was available to provide: -transfers with assist of one staff; -transfers utilizing sit-to-stand lifts; and -mechanical lift: assist of one transfer. No further information provided. TIME PERIOD TO CORRECT: Seven (7) days	01020		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a cleared	01290	During the course of the survey, the licensee took action to mitigate the	

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01290	Continued From page 16 Minnesota Department of Human Services (DHS) background study clearance prior to providing services for three of four employees (unlicensed personnel (ULP)-D, ULP-F, ULP-G). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's health facility identification number (HFID) was 30698 and the licensee provided assisted living services beginning August 1, 2021. ULP-D ULP-D was hired on July 5, 2024, and provided direct care services to the licensee's residents. On January 13, 2025, at 11:21 a.m., the surveyor observed ULP-D assist residents with medication and treatment administration. ULP-D's employee record included a DHS background study clearance letter dated January 13, 2025. The letter indicated ULP-D's background study was completed after initiation of the survey. ULP-F ULP-F was hired on December 29, 2024, and provided direct care services to the licensee's residents.	01290	immediate risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	Continued From page 17 ULP-F's employee record lacked evidence of a cleared DHS background study. ULP-G ULP-G was hired on October 13, 2024, and provided direct care services to the licensee's residents. ULP-G's employee record included a DHS background study clearance letter dated January 13, 2025. The letter indicated ULP-G's background study was completed after initiation of the survey. On January 14, 2025, at 10:30 a.m., the surveyor observed the licensee's DHS Net Study 2.0 website and roster with licensed assisted living director (LALD)-A. ULP-D, ULP-F, and ULP-G's employee records lacked evidence of a cleared background study affiliated with the licensee's HFID on the DHS Net Study 2.0 Roster at the time of survey initiation. On January 14, 2025, at 10:35 a.m., LALD-A stated ULP-D, ULP-F, and ULP-G were currently providing services to the licensee's residents. Also, LALD-A stated a background study was not completed for ULP-D, ULP-F, and ULP-G, until January 13, 2025, during the survey. LALD-A verbalized he completed the background study after the initiation of the survey, and stated somehow, he overlooked these with the process he used for monitoring the background studies of the licensee's employees. The licensee's undated Personnel Records policy indicated, "The personnel record for each person will include: a. Evidence of current professional licensure,	01290		

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01290	Continued From page 18 registration or certificate, if licensure, registration, or certification is required by the home care law or other state requirements; b. Record of home care orientation; c. Record of all required training for unlicensed personnel and competency determinations; d. Record of required in-service education for all staff providing home care services to clients; e. Documentation of a completed criminal background study; f. Documentation that the employee is not on the OIG or MHCP exclusion list; g. TB screening results (and other documentation related to communicable diseases, if appropriate); h. Results of supervision observations i. Performance evaluations which identify areas of improvement needed and training needs [performance reviews must be conducted at least annually]; j. Current job description, which includes qualifications, responsibilities and identification of supervisors." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

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01890	Continued From page 19 by: Based on observation, interview, and record review the licensee failed to date time-sensitive medications with opened or expiration dates 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 medical record included a signed Service Plan (Waiver) - Addendum to Contract dated December 27, 2024, and indicated R2 received assistance including housekeeping, laundry, dressing, grooming, bathing, mobility, blood glucose monitoring, and medication administration. On January 13, 2025, at 12:08 p.m., the surveyor observed unlicensed personnel (ULP)-D assist R2 with medication administration. R2's locked medication drawer located in the licensee's locked medication closet included one opened Lispro (fast-acting insulin) pen. ULP-D administered two units of Lispro insulin to R2 according to R2's provider orders. R2's Lispro insulin pen lacked an opened date to indicated when it was first opened and used. ULP-D stated the caregivers were trained by the nurse to label the insulin pens when opened but this must have been missed.	01890		

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01890	Continued From page 20 The manufacturer's instructions for Lispro insulin pens revised July 2023, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. On January 13, 2025, at 12:15 p.m., clinical nursing supervisor (CNS)-B confirmed there was no open date documented on R2's Lispro insulin pen. Also, CNS-B stated the staff were trained to label and date multi-use insulin pens when opened. CNS-B verbalized she planned to complete education with the staff. The licensee's Storage of Medication policy, dated March 7, 2020, included "2. Proper Storage of Medications a. Medication at Project Caring will be stored in locked medication cart or in locked medication closet in the locked office. b. The RN will provide education on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. c. Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed phannacy {sic} that issued the medications. d. An over-the-counter drug must be kept in the original labeled container from the pharmacy or manufacturer. e. The RN will also identify in the client's individualized medication management plan a	01890		

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01890	Continued From page 21 process for monitoring or tracking a client's controlled or other medications that might be at risk of diversion." The licensee's Safe Insulin Administration policy dated February 20, 2020, included, "6. Storage of Insulin: -Insulin should be stored according to manufacturer recommendations, typically between 36°F and 46°F (2°C to 8°C), and never frozen. -Opened insulin vials may be stored at room temperature for up to 28 days, but must be clearly labeled with the opening date. -Insulin pens or vials will be kept in a secure location, accessible only to authorized personnel." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R2) who utilized hospital style bed rails.	02310	During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.	

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02310	Continued From page 22 In addition, the licensee failed to ensure proper safe storage of oxygen (O2) tanks for one of one resident (R4). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: BEDRAILS On January 14, 2025, at 8:26 a.m., the surveyor observed the bedrooms of the facility with unlicensed personnel (ULP)-E. R2's bedroom included one hospital style bed with bilateral (both sides) upper side rails. Both side rails were in the upright position. R2 was admitted on December 27, 2024, and had diagnoses which included cerebral arteritis (a rare disorder that involves inflammation of the blood vessels in the brain), aphasia (difficulty understanding or expressing language), and type two diabetes (body doesn't make enough insulin or doesn't use insulin well). R2's medical record included a signed Service Plan (Waiver) - Addendum to Contract dated December 27, 2024, and a copy of "A Guide to Bed Safety Brochure" was received by R2. R2's service plan indicated R2 received assistance with housekeeping, meals, laundry, bathing, grooming, toileting, blood glucose testing, and medication administration.	02310		

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02310	Continued From page 23 R2's medical record included a nursing assessment dated December 30, 2024, which indicated under the section labeled "Safety" - "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed." R2's medical record lacked: -side rail use assessment; and -documentation of measurements of zones of entrapment. On January 14, 2025, at 8:56 a.m., clinical nurse supervisor (CNS)-B stated R2 just had a new bed delivered on Friday January 10, 2025, in the afternoon, and CNS-B didn't realize the bed had side rails until the time of survey when surveyor asked her about R2's side rails. Also, CNS-B verbalized she was not notified by the staff when the bed arrived that it included bilateral upper side rails. On January 14, 2025, at 9:03 a.m., CNS-B stated she had not completed R2's side rail assessment but planned to get this completed right now. Also, CNS-B verbalized her process was to complete a side rail assessment for any resident that had a side rail, but she was not made aware of R2's side rail until the surveyor brought it to her attention. On January 14, 2025, at 9:10 a.m., via email, licensed assisted living director (LALD)-A shared a text message which indicated R2's hospital style bed was delivery in the afternoon of Friday January 10, 2025. The licensee's Assessing the Safety of Side Rails	02310		

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02310	Continued From page 24 policy dated February 27, 2020, included "1. The RN or LPN will train staff to be alert for any side rail or equipment that resembles a side rail that a client may be using or considering using and to notify the RN immediately about the side rail or equipment. 2. When notified that a client has a side rail, the RN or LPN will assess and evaluate what the client's needs are and assess to determine if the client can safely utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA standards for side rails. It is suggested that the client be referred for a therapy evaluation to determine appropriate alternative methods or devices to meet their expressed needs. 3. The RN or LPN will provide for any client who has a side rail or is considering obtaining one education regarding side rail safety and risks including potential death due to falls, entrapment, and asphyxiation. If the RN or LPN determines that the client is not able to safely use a side rail, or that the client's side rail does not meet the FDA or most current safety guidelines, the RN or LPN will recommend that the side rail should be removed and will document this recommendation, will document to whom the education was directed and will document the person who was given the recommendation to remove the side rail." The Food and Drug Administration (FDA)'s, A Guide to Bed Safety, dated March 10, 2006, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep	02310		

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02310	Continued From page 25 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 12, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided.	02310		

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02310	Continued From page 26 TIME PERIOD FOR CORRECTION: Immediate OXYGEN STORAGE R4 was admitted December 27, 2022, and had diagnoses including aphasia, congestive heart failure (long-term condition when your heart can't pump blood well enough to give your body a normal supply), and dyspnea (shortness of breath). R4's Service Plan (Waiver) - Addendum to Contract dated December 27, 2022, indicated R4 received services housekeeping, laundry, meals, bathing, grooming, compression socks, and medication administration. R4's medical record included a provider order dated May 22, 2024, for oxygen to be administered at two liters per minute (lpm) via nasal cannula (a tubing to deliver oxygen through your nose) 24 hours per day, and oxygen at three lpm with activity. R4's Med Admin Summary - Actual - Month dated January 1, 2025, through January 15, 2025, indicated R4 received, "Oxygen (Daily) 2 L {liters} at rest continuous (Bedtime) on concentrator and 3 L with activity continuous nasal cannula oxygen flow on portable tank." The medication administration summary noted R4 refused oxygen administration on all days except at bedtime on January 8, 2025. On January 14, 2025, at 8:44 a.m., the surveyor observed ULP-E assist R4 with medication administration. R4's room was observed to have three O2 tanks sitting on the floor under a window, and not secured to prevent tipping. ULP-E stated R4 had been refusing the oxygen. Also, R4 verbalized he did not like to wear the	02310		

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02310	Continued From page 27 oxygen and was not currently using it. On January 14, 2025, at 9:03 a.m., CNS-B stated R4 had been refusing to wear the oxygen and CNS-B verbalized she was not aware the oxygen cylinders were required to be secured to prevent tipping. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements (based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code), dated April 16, 2020, indicated the types of hazards associated with oxygen as: 1) General fires and explosions enhanced by oxygen-rich atmospheres 2) Mechanical problems such as physical damage to compressed gas cylinders. The guidance further indicated, "when storing up to 300 cubic feet (ft^3) of oxygen, cylinders must be secured (chains or racks) to prevent them from falling over". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *01/13/25*
Time: 11:00:00
Report: 1031251011

Food and Beverage Establishment Inspection Report

Location:
Project Caring
14410 21st Street North
Stillwater, MN55082
Washington County, 82

Establishment Info:
ID #: 0037659
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514850860
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISH MACHINE MEASURED < 160F.

DISCONTINUE USE OF DISH MACHINE FOR SANITIZING UNTIL REPAIRED OR REPLACED.
CAN BE USED FOR WASH/RINSE. FILL SINK WITH BLEACH WATER (50-200PPM) AND SANI DIP DISHES AFTER WASHING. ALLOW DISHES TO AIR DRY.

Comply By: 01/14/25

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.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE.

PROVIDE IRREVERSIBLE MEASURING AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 01/16/25

Type: Full
Date: *01/13/25*
Time: 11:00:00
Report: 1031251011
Project Caring

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE.

PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)
Comply By: 01/16/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
LIGHT ON COOKING SURFACE HOOD NOT WORKING.

REPLACE BULB OR REPAIR HOOD.
Comply By: 02/04/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sani Spray
Violation Issued: No

Hot Water: < at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/Deli Meat
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Hot Dogs
Temperature: 41 Degrees Fahrenheit - Location: Downstairs Refrigerator
Violation Issued: No

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

Nurse Evaluator on site: Dede Hinnendael

All violations discussed with PIC during the inspection.

contact inspector once dish machine is repaired.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be

removed/discarded at end of day.

- Staff must prepare sanitizer bucket or squirt bottle daily. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has right basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031251011 of 01/13/25.

Certified Food Protection Manager: Angela Rose Jurkovsik

Certification Number: 53568 Expires: 10/06/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Angela Rose Jurkovsik
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian III
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us