Electronically Delivered

September 13, 2024

Licensee
First Choice Nursing Services Inc.
10510 France Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL33987015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 14, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.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
	33987	A. BUILDING: _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	10510 FRANCE AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER 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: SL33987015-0 On August 12, 2024, through August 14, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one (1) resident, who received services under the provider's Assisted Living 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 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 13, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

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0 550	Continued From page 2 procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities (OOLTC/OMHDD), as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all of the licensee's current 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 the potential to affect a large portion or all the residents).	0 550		

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0 550	Continued From page 3 The findings include: On August 12, 2024, at 11:02 a.m., during a facility tour conducted with administrator (A)-A, the surveyor observed the entry area and common areas, and noted there was no posting of the grievance procedure with the required information and information related to reporting suspected maltreatment to MAARC. On August 12, 2024, at 11:05 a.m., A-A stated he was not sure where the required posting had gone, and would provide another posting. A-A further stated they had not had any residents in the facility for quite a while, however, just admitted a new resident the previous week. The licensee's Complaint/Grievance Posting policy dated November 1, 2021, indicated the licensee would post, in a conspicuous place, information about their complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who would be responsible for handling resident complaints/grievances. Furthermore, the posting would also have the contact information for the OOLTC/OMHDD, and information for reporting suspected maltreatment to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 4 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for two of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 facility TB risk assessment dated August 9, 2024, indicated the facility was a low risk setting	0 660		

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0 660	Continued From page 5 for TB transmission. CNS-B was hired December 31, 2023, and provided direct cares for residents of the facility. CNS-B's employee record included a TB history and symptom screening form completed, December 30, 2023; however, lacked documentation of baseline TB screening test results. ULP-C was hired July 17, 2024, and provided direct cares for residents of the facility. ULP-C's employee record included a TB history and symptom screening form completed October 2, 2023, which was greater than 90 days prior to hire date. ULP-C's TB history and symptom screening form indicated ULP-C had previously had a positive reaction to a TB skin test or TB blood test, but the record lacked documentation of the result including the date of the positive test. ULP-C's employee file indicated a chest x-ray (CXR) was authorized October 2, 2023, but lacked documentation the CXR was completed and the result. On August 12, 2024, at 1:20 p.m., administrator (A)-A stated ULP-C's employee record lacked documentation of a TB test and CXR. A-A indicated ULP-C had been out of the country for the past six months, would be treated as a new hire upon returning to work, and would need to complete a new TB symptom screening. A-A further stated ULP-C was on the schedule to work overnight on August 12, 2024, however, would be taken off the schedule until they obtained documentation of a positive reaction to a TB skin test or TB blood test, and a subsequent negative CXR result.	0 660		

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0 660	Continued From page 6 On August 14, 2024, at 3:29 p.m., A-A stated CNS-B used to work at a different facility and had her TB test done there. Furthermore, A-A stated they did not obtain the result for CNS-B's employee record. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening policy, dated November 1, 2021, indicated the licensee would establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). Furthermore, the policy indicated screening would be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where	0 660		

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0 660	Continued From page 7 the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (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	0 680		

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0 680	Continued From page 8 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 (EP) plan with all the required content. 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 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 13, 2024, at 10:15 a.m., the licensee's undated EP plan lacked evidence it was reviewed annually, lacked the current facility address and phone number, and lacked the following requirements: - Policy and procedure to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - Policy and procedure for use of volunteers; - Policy and procedure with arrangement agreements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - Must conduct exercises to test the EP at least	0 680		

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0 680	Continued From page 9 twice per year, including unannounced staff drills using the EP; - Must participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On August 13, 2024, at 1:28 p.m., administrator (A)-A stated the licensee worked with a consultant on the required content of the EP plan. The licensee's Disaster Planning and Emergency Preparedness policy dated November 1, 2021, indicated, licensee would have in place a general emergency preparedness plan, that was in alignment with the licensee's requirement to also comply with Centers for Medicare and Medicaid Services (CMS) Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's	0 730		

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0 730	Continued From page 10 name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation,	0 730		

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0 730	Continued From page 11 when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete a discharge summary for two of two discharged residents (R2, R3). 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: R2 R2 started services April 15, 2024, and was admitted to the hospital on July 17, 2024. R2 was transferred to a treatment center post hospitalization; therefore, had been discharged from the facility. R2's record lacked evidence a discharge summary was completed. R2's diagnoses included, but were not limited to, schizo-affective disorder, diabetes mellitus type 2, neuropathy, and insomnia. R2's service plan dated April 15, 2024, indicated R2 received services including assistance with medication management, weekly medication setup, and medication administration, twice daily and as needed (PRN).	0 730		

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0 730	Continued From page 12 R3 R3 started services April 12, 2024, and was admitted to the hospital on June 27, 2024. R3 transferred to a treatment center post hospitalization; therefore, had been discharged from the facility. R1's record lacked evidence a discharge summary was completed. R3's diagnoses included, but were not limited to, schizo-affective disorder, bipolar disorder, and asthma. R3's service plan dated April 12, 2024, indicated R3 received services including assistance with medication management, weekly medication setup, and medication administration, three times daily and PRN. On August 13, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated a discharge summary had not been completed for either R2 or R3. CNS-B further stated R2 and R3 were each sent to the hospital and never returned to the facility. CNS-B further stated they never thought about completing a discharge summary for R2 or R3. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated residents discharged or transferred from facility would have a coordinated process for discharge or transition to another provider/setting. The licensee's policy did not indicate the required content of a discharge summary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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	33987	A. BUILDING: _____ B. WING _____	08/14/2024

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0 780	Continued From page 13	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. 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	0 780		

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0 780	Continued From page 14 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 August 13, 2024, from 11:30 a.m., to 12:30 p.m., with administrator (A)-A, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. During the tour, A-A tested the alarms and the smoke alarms inside and outside the upstairs resident sleeping room and in the basement were not interconnected to the alarms on the main floor so activation of one alarm activates all alarms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and A-A verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 15 (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 August 13, 2024, from 11:30 a.m., to 12:30 p.m., with administrator (A)-A, it was observed that the required fire extinguisher had a manufacture date of 2018 with no documentation of required annual service. 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	0 790		

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0 790	Continued From page 16 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 the tour A-A verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and 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	0 800		

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0 800	Continued From page 17 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 a facility tour on August 13, 2024, from 11:30 a.m., to 12:30 p.m., with administrator (A)-A, the surveyor made the following observations of facility hazard or disrepair: There was a keyed lock installed outside the door on the non-egress side of the door preventing exiting from resident sleeping room 3 at the bottom of the stairs leading to resident sleeping room 3 upstairs. Doors in the exit route are required to open from the egress side in the direction of travel without the use of keys, tools, or special knowledge according to current Minnesota Fire Code. The building electrical service panel is installed at an angle, the door was removed, the cover was not fully installed and was not fully accessible for service in the basement. The electrical service panel is required to be maintained as designed and installed at the time of construction approval. There was an electrical wire with a cut, exposing electrical wires above the electrical service panel in the basement. The electrical wires are required to be maintained as installed at the time of construction approval. The resident sleeping room 2, emergency escape and rescue window operating hardware was broken. The window opened fully but the hardware was disconnected, and the window	0 800		

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0 800	Continued From page 18 would not close. There was only a deadbolt and not a door handle latch installed on the door leading to the basement. Doors in the exit route are required to be provided with a latch and handle to open for exiting according to current Minnesota Fire Code. There was only a deadbolt and not a door handle latch installed on the door leading into the bathroom near the dining room. Doors in the exit route are required to be provided with a latch and handle to open for exiting according to current Minnesota Fire Code. There was damage to the ceiling in the back porch caused by a water leak in the roof of the porch. There was damage to the roof line on the front second story of the facility. During the tour on August 13, 2024, at 12:15 p.m., A-A stated a tree fell on the roof and they need to get a contractor to fix the damage to the roof. There was an open electrical box exposing electrical wires in the ceiling of the storage room in the basement. The ventless dryer in the basement had a drain hose that was not discharging to an approved location. The water discharge hose is required to drain to an approved location in accordance with the manufacture's installation instructions. During a facility tour on August 13, 2024, at 12:30 p.m., A-A verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 19 days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (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.	0 810		

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0 810	Continued From page 20 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: During observation on August 13, 2024, at 12:50 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 in a locked cabinet in the kitchen. On August 13, 2024, at 12:35 p.m., administrator (A)-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 provided FSEP, failed to include the following: The evacuation floor plan was not posted on the second story or in the basement in order for	0 810		

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0 810	Continued From page 21 occupants to use for direction in the event of fire or similar emergency. The FSEP did not identify specific fire protection actions for residents evident by not providing procedures in writing in the plan and readily available, for residents to take during a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include evacuation status and unique needs for each residents evacuation in writing in the plan and readily available. During an interview on August 13, 2024, at 1:00 p.m., A-A stated resident actions in the event of a fire or similar emergency and resident evacuation status for each resident was not available with the FSEP. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing residents were provided the annual training as required. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation training was provided to staff as required. During an interview on August 13, 2024, at 12:55	0 810		

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0 810	Continued From page 22 p.m., A-A stated there was no training provided to staff because there were no residents in the facility until August 8, 2024, and documentation was not available FSEP training was provided to the resident at admission. Staff training on the FSEP is required even when residents are not occupying the facility in order to be prepared when residents are admitted. DRILLS Record review of the available documentation 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 providing documentation evacuation drills were completed on June 5, 2024, only. During an interview on August 13, 2024, at 12:55 p.m., A-A stated drills were not completed and documented because there were no residents admitted. Evacuation drills are required even when residents are not occupying the facility in order to be prepared when residents are admitted. No further information 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. (b) The contract must contain all the terms	0 900		

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0 900	Continued From page 23 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 interview, and record review, the licensee failed to develop and execute a written contract with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	0 900		

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0 900	Continued From page 24 of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to licensee on August 7, 2024. R1's record lacked a written contract which included all of the required terms concerning the provisions of the following: - housing; - assisted living services, whether provided directly by the facility or by management agreement or other agreement; - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - 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; - 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; and - 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. On August 13, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated R1 was not given a written contract upon admission to the facility. CNS-B further stated, R1's records were transferred from another sister community, and the contract that had been developed at the sister facility was the contract the licensee had been using.	0 900		

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0 900	Continued From page 25 The licensee's Signing an Assisted Living Contract policy dated November 1, 2021, indicated when a prospective resident decided to move into the licensee's facility, an Assisted Living contract would be signed and received by the facility. Furthermore, the blanks of the contract would be filled in, and a copy of the contract would be provided to the prospective resident and/or responsible person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
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	01060		

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01060	Continued From page 26 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 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 an 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) when the resident did not return from the emergency relocation within four days for one of one resident (R3). 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	01060		

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	33987	A. BUILDING: _____ B. WING _____	08/14/2024

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01060	Continued From page 27 the residents). The findings include: R3's Service/Care Plan dated April 12, 2024, indicated R3 received services including assistance with medication management, medication administration, weekly vital signs, meal preparation, and cues/supervision with activities of daily living. R3's Resident Progress Notes included the following: - July 1, 2024, indicated R3 drank a large bottle of mouthwash, was "not feeling well", and was transported to the hospital for further evaluation. - July 12, 2024, indicated R3 discharged from the hospital on July 11, 2024, directly to a treatment facility; therefore, was discharged from licensee's facility. R3's record lacked documentation the required written emergency relocation notice was provided, that contained, 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 OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); (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	01060		

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01060	Continued From page 28 may submit an appeal. The record lacked documentation the required notice was 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 OOLTC if the resident had been relocated and had not returned to the facility within four days. On August 13, 2024, at 11:32 a.m., clinical nurse supervisor (CNS)-B indicated the licensee was not aware of the required notice, the content of the notice, or the required OOLTC notification if a resident did not return within four days. CNS-B stated no residents who had an emergency relocation would have received the required notice. Licensee's Emergency Relocation policy dated November 1, 2021, indicated in the event of an emergency relocation, licensee would provide a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal. Furthermore, the notice required would be delivered to the OOLTC if the resident had been relocated and had not	01060		

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01060	Continued From page 29 returned to the facility within four (4) days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	01370		

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01370	Continued From page 30 cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed with all required content for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on July 10, 2024, to provide direct care services to residents of the assisted living facility. On August 13, 2024, at 9:45 a.m., ULP-D was observed obtaining R1's blood pressure, pulse, and oxygen saturation level (test to determine the level of oxygen in the blood stream). ULP-D was further observed preparing and administering oral medications to R1.	01370		

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01370	Continued From page 31 ULP-D's employee record lacked documentation of training and competency evaluations for ULPs including: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care and use of hearing aids; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On August 13, 2024, at 11:42 a.m., administrator (A)-A stated ULPs had not been trained and competency tested on the required training topics listed above. A-A further stated it was his understanding that training and competency testing would be specific to the facility and the types of services provided to their residents. The licensee's Competency and Training policy dated November 1, 2021, indicated prior to the registered nurse delegating services, they would make certain the ULP was trained in the proper methods to perform the tasks or procedures for each resident and was able to demonstrate the ability to competently follow the procedures and perform the tasks, prior to working for the licensee. In addition, the policy directed only ULP's who were determined to be competent and possessed the knowledge and skills consistent with the complexity of tasks being delegated would be permitted to perform such delegated	01370		

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01370	Continued From page 32 tasks. Training and competency evaluations for all ULP providing assisted living services would include: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care and use of hearing aids; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident;	01380		

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01380	Continued From page 33 (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed with all required content for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on July 10, 2024, to provide direct care services to residents of the assisted living facility. On August 13, 2024, at 9:45 a.m., ULP-D was observed obtaining R1's blood pressure, pulse, and oxygen saturation level (test to determine the level of oxygen in the blood stream). ULP-D was further observed preparing and administering oral medications to R1. ULP-D's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: - reading and recording temperature, pulse, and	01380		

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01380	Continued From page 34 respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. On August 13, 2024, at 9:10 a.m., ULP-D stated the registered nurse (RN) trained her on obtaining vital signs and medication administration. On August 13, 2024, at 11:42 a.m., administrator (A)-A stated ULPs were trained on obtaining vital signs and medication administration; however, competency testing was not documented in ULP-D's employee file. Furthermore, A-A stated ULPs had not been trained and competency tested on the additional required training topics listed above. A-A further stated it was his understanding that training and competency testing would be specific to the facility and the types of services provided to their residents. The licensee's Competency and Training policy dated November 1, 2021, indicated prior to the registered nurse delegating services, they would make certain the ULP was trained in the proper methods to perform the tasks or procedures for each resident and were able to demonstrate the ability to competently follow the procedures and perform the tasks, prior to working for the licensee. In addition, the policy directed only ULP's who were determined to be competent and possessed the knowledge and skills consistent with the complexity of tasks being delegated would be permitted to perform such delegated tasks. Furthermore, training and competency evaluations for all ULP providing assisted living services would include: -Reading and recording temperature, pulse, and respirations of the resident;	01380		

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01380	Continued From page 35 -Recognizing physical, emotional, cognitive, and developmental needs of the resident; -Safe transfer techniques and ambulation; and -Range of motioning and positioning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of	01910		

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01910	Continued From page 36 medication to include quantity and names of staff and other individuals involved in the disposition of medications for two of two discharged residents (R2, R3). 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: R2 R2 started services April 15, 2024, and was admitted to the hospital on July 17, 2024. R2 was transferred to a treatment center post hospitalization; therefore, had been discharged from the facility. R2's diagnoses included, but were not limited to, schizo-affective disorder, diabetes mellitus type 2, neuropathy, and insomnia. R2's service plan dated April 15, 2024, indicated R2 received services including medication management, weekly medication setup, and medication administration, twice daily and as necessary (PRN). R2's medication administration record dated July 2024, indicated R2 was assisted with medication administration by unlicensed personnel (ULP), for the following medications: Tresiba FlexTouch (used for diabetes mellitus), Haloperidol Decanoate (used to treat schizophrenia),	01910		

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01910	Continued From page 37 melatonin (used for sleeping aid), divalproex sodium (used for mania and depression), gabapentin (used for nerve pain), rosuvastatin (used to treat high cholesterol), trazodone HCL (used for anxiety and depression), ropinirole HCL (used for restless leg syndrome), cephalexin (used to treat infection), doxycycline (used to treat infection), acetaminophen (used to treat pain), and NovoLog (used for diabetes mellitus). R2's record lacked documentation of disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. R3 R3 started services April 12, 2024, and was admitted to the hospital on June 27, 2024. R3 transferred to a treatment center post hospitalization; therefore, had been discharged from the facility. R3's diagnoses included, but were not limited to, schizo-affective disorder, bipolar disorder, and asthma. R3's service plan dated April 12, 2024, indicated R3 received services including assistance with medication management, weekly medication setup, and medication administration, three times daily and PRN. R3's medication administration record dated June 2024, indicated R3 was assisted with medication administration for the following medications: Coreg (used to treat high blood pressure), lisinopril (used to treat high blood pressure, ropinirole (used to treat restless leg syndrome),	01910		

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01910	Continued From page 38 rosuvastatin (used to treat high cholesterol), aspirin (used for heart health), and topiramate (used to treat seizures). R3's record lacked documentation of disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On August 13, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated the disposition of medications was not documented for discharged residents R2 and R3. CNS-B further stated she was unaware of the requirement. The licensee's Medication Disposal policy dated November 1, 2021, indicated upon disposition, the licensee would document in the resident's record the disposition of the medication including, the medication's name, strength, prescription number as applicable, quantity, to whom the medications would be given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."	03090		

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03090	Continued From page 39 (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at all entrances to the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents in the assisted living facility, staff, and visitors. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 12, 2024, at 10:00 a.m., the surveyor observed outside the front entrance and just inside the front entrance to the facility. There was no required posting for electronic monitoring devices. On August 12, 2024, at 11:02 a.m., during a facility tour conducted with administrator (A)-A. A-A stated there was no posting at the facility entrance including the statutory language for electronic monitoring. A-A further stated he would be the person responsible to ensure the required posting was present. The licensee's Electronic Monitoring policy dated	03090		

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03090	Continued From page 40 November 1, 2021, indicated the licensee would support the use of electric monitoring by their residents and resident representatives (as defined by law). The policy further indicated signs would be installed at each facility entrance accessible to visitors that stated: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *08/13/24*
Time: 14:00:01
Report: 7963241084

Food and Beverage Establishment Inspection Report

Location:
First Choice Nursing And Homec
10510 France Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037653
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633233092
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

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

ESTABLISHMENT HAS NO EFFECTIVE MEANS TO SANITIZE DISHES AND UTENSILS. EITHER PROVIDE A HIGH TEMP DISHMACHINE OR A THREE COMPARTMENT SINK WITH CHEMICAL SANITIZER. USE A SEPERATE DISH BASIN TO SANITIZE DISHES UNTIL THIS IS RESOLVED. FACT SHEET EMAILED.

Comply By: 10/13/24

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD MANAGER CERTIFICATE ON SITE. FACT SHEET AND APPLICATION EMAILED WITH REPORT.

Comply By: 08/13/24

Food and Equipment Temperatures

Process/Item: HOT DOG
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

MET WITH JERRY HAVON AND MDH NURSE SURVEYOR RHONDA MALEKA.
DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-HIGHLY SUSCEPTIBLE POPULATIONS REQUIREMENTS
-REQUIREMENTS FOR WASHING AND SANITIZING DISHES

THIS IS A RESIDENTIAL KITCHEN. CEILING IN POPCORN TEXTURE, WOOD CABINETS, LAMINATE COUNTERTOP AND LAMINATE FLOOR.

NO THREE COMPARTMENT SINK OR DISHWASHER ON SITE.

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 7963241084 of 08/13/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Jerry Havon
PIC

Signed:_____
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963241084

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	2	**Date**	08/13/24
No. of Repeat RF/PHI Categories Out	0	**Time In**	14:00:01
Legal Authority MN Rules Chapter 4626		**Time Out**	

First Choice Nursing And Homec	**Address** 10510 France Avenue North	**City/State** Brooklyn Park, MN	**Zip Code** 55443	**Telephone** 7633233092
License/Permit # 0037653	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygenic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
Proper cooking time & temperature			
19	IN OUT N/A N/O		
Proper reheating procedures for hot holding			
20	IN OUT N/A N/O		
Proper cooling time & temperature			
21	IN OUT N/A N/O		
Proper hot holding temperatures			
22	IN OUT N/A		
Proper cold holding temperatures			
23	IN OUT N/A N/O		
Proper date marking & disposition			
24	IN OUT N/A N/O		
Time as a public health control: procedures & records			
Consumer Advisory			
25	IN OUT N/A		
Consumer advisory provided for raw/undercooked food			
Highly Susceptible Populations			
26	IN OUT N/A		
Pasteurized foods used; prohibited foods not offered			
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
Food additives: approved & properly used			
28	IN OUT		
Toxic substances properly identified, stored, & used			
Conformance with Approved Procedures			
29	IN OUT N/A		
Compliance with variance/specialized process/HACCP			

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/14/24

Inspector (Signature) Peggy Spudy