DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

May 1, 2024

Licensee
At Home With Us LLC
2174 Stanich Street
Maplewood, MN  55109

RE: Project Number(s) SL34811015

Dear Licensee:

On April 22, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 8, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34811 | A. BUILDING: _____ B. WING _____ | R 04/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AT HOME WITH US LLC | 2174 STANICH STREET MAPLEWOOD, MN 55109 |

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| {0 000} | Initial Comments<br><br>*****ATTENTION******<br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey.<br>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.<br>INITIAL COMMENTS:<br>SL34811015-1<br>On April 22, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 8, 2024. At the time of the survey, there were 5 residents; all receiving services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance. | {0 000} | | |
| {0 480} SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>No further action needed. | {0 480} | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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| {0 660} | Continued From page 1 | {0 660} | | |
| {0 660} SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>No further action needed. | {0 660} | | |
| {0 680} SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; | {0 680} | | |

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| {0 680} | Continued From page 2<br><br>and<br>(5) have a written policy and procedure regarding missing residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>No further action needed. | {0 680} | | |
| {01830} SS=F | 144G.71 Subd. 14 Renewal of prescriptions<br><br>Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.<br><br>This MN Requirement is not met as evidenced by:<br>No further action needed. | {01830} | | |
| {02310} SS=D | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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. | {02310} | | |

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| {02310} | Continued From page 3<br>This MN Requirement is not met as evidenced by:<br>No further action needed. | {02310} | | |
| {02430} SS=C | 144G.91 Subd. 15 Confidentiality of records<br><br>(a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party.<br>(b) Residents have the right to access their own records.<br><br>This MN Requirement is not met as evidenced by:<br>No further action needed. | {02430} | | |

Electronically Delivered

February 28, 2024

Licensee
At Home With Us, LLC
2174 Stanich Street
Maplewood, MN 55109

RE: Project Number(s) SL34811015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 8, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

**STATE CORRECTION ORDERS**

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

**IMPOSITION OF FINES**

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

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

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

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

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

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

**St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = $3,000.00**

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

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

The correction order documentation should include the following:

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

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

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

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L Anderson

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

PMB

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL34811015<br><br>On February 5, 2024, through February 8, 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 were 5 residents receiving services under the provider's Assisted Living Facility license.<br><br>An immediate correction order was identified on February 6, 2024, issued for SL34811015, tag identification 0820.<br><br>On February 7, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G. | 0 000 | Minnesota Department of Health is documenting the State Licensing 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.<br><br>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.<br><br>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 pursuant to 144G.31 Subd. 1, 2 and 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<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 6, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control | 0 660 | | |

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| 0 660 | Continued From page 2<br><br>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.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either by a two-step tuberculin skin test (TST) or a single IGRA blood test) was completed and documented for two of two employees (unlicensed personnel (ULP)-B, ULP-D).<br><br>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).<br><br>The findings include: | 0 660 | | |

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| 0 660 | Continued From page 3<br><br>ULP-B and ULP-D had a hire date of July 20, 2022, and September 27, 2019, respectfully.<br><br>On February 5, 2024, at 2:15 p.m., ULP-B and ULP-D were observed to assist R1 with bathing.<br><br>ULP-B's employee record contained a 1st step TB skin test dated May 2,2023, but lacked documentation of a 2nd step being completed.<br><br>ULP-D's record contained a letter from a physician, dated March 31, 2020, that indicated ULP-D had a latent TB infection and could return to work. ULP-D's record lacked documentation of a previous positive TST or IGRA or a documented chest x-ray following the date of a positive TST or IGRA.<br><br>On February 7, 2024, at 1:15 p.m., clinical nurse supervisor/owner (CNS/O)-A stated she had thought the physician's letter would be sufficient for the TB screening. CNS/O-A further stated she did not realize ULP-B had not done the second step of the TB skin test.<br><br>The CDC's Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC dated May 16, 2019, recommend all health care professionals complete a TB screening including a symptom evaluation and an interferon gamma release assay (IGRA) or TST. Health care workers with written documentation of a previous positive TST or IGRA should have documented in their record: test results, assessment for current TB symptoms and a related chest x-ray.<br><br>The licensee's 8.16 Tuberculosis Screening policy, dated August 1, 2021, indicated baseline | 0 660 | | |

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| 0 660 | Continued From page 4<br><br>testing would be completed upon hire and would consist of either a two-step TST or single IGRA blood test. The policy further indicated TB screening results would be kept in each employee medical file.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule. | 0 680 | | |

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| 0 680 | Continued From page 5<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license.<br><br>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).<br><br>The findings include:<br><br>The licensee's EPP, last reviewed January 19, 2024, lacked the following required content:<br>-Development of emergency preparedness policies and procedures addressing:<br>-how the facility will provide a means to shelter in place for residents, and volunteers;<br>-provision of subsistence needs for staff and residents to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems);<br>-a tracking system used to document locations of residents and staff;<br>-medical record documentation system the facility has developed to preserve resident information security and availability of records;<br>-emergency staffing strategies to include volunteers; and | 0 680 | | |

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| 0 680 | Continued From page 6<br><br>-the development of arrangements with other facilities and providers to receive residents if needed.<br>-Development of communication plan to include:<br>-names and contact information for staff, entities providing services under arrangement, resident physicians, other visitors, volunteers;<br>-contact information for federal, state, tribal, local emergency preparedness staff, ombudsman, state licensing and certification agencies;<br>-primary and alternative means for communicating with facility staff, federal, state, tribal, regional, and local emergency management agencies;<br>-methods for sharing information and medical documentation for residents;<br>-means of providing information about the facility's needs, and its ability to provide assistance to include information about their occupancy; and<br>-methods for sharing information from the emergency plan with residents and families.<br><br>On February 7, 2024, at 1:10 p.m., clinical nurse supervisor/owner (CNS/O)-A, stated the licensee was working on completing the missing items from Appendix Z.<br><br>The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance, dated August 1, 2021, indicated the emergency preparedness plan would include all required element of Appendix Z.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34811 | A. BUILDING: _____ B. WING _____ | 02/08/2024 |

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| 0 800 | Continued From page 7 | 0 800 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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).<br><br>Findings include:<br><br>On a facility tour on February 6, 2024, at 11:10 a.m., with physical plant manager (PPM)-E and clinical nurse supervisor/owner (CNS/O)-A, the surveyor made the following observations of facility hazards and disrepair: | 0 800 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| 0 800 | Continued From page 8<br><br>Exit signs were installed leading occupants of the assisted living through the laundry room and garage to exit the assisted living in the event of an emergency. Exits are required to lead through one intervening room of equal or less hazard in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511.<br><br>The evacuation floor plan indicated the room currently used as an office as bedroom 4. The floor plan is required to be labeled accurately and identify room 4 as an office, to assist occupants with direction in an evacuation during a fire or similar emergency. It was also observed the room labeled bedroom number 4 on the evacuation floor plan failed to include an emergency escape and rescue opening as required for a bedroom in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511.<br><br>During a facility tour on February 6, 2024, at 11:30, PPM-E, and CNS/O-A, verified the above listed observations while accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for | 0 810 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 0 810 | Continued From page 9<br><br>residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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 | 0 810 | | |

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|---|---|---|---|
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| 0 810 | Continued From page 10<br><br>or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On February 6, 2024, at 11:10 a.m., physical plant manager (PPM)-E, and clinical nurse supervisor/owner (CNS/O)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br><br>The licensee FSEP dated August 1, 2021, failed to include the following:<br><br>The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan inappropriately included information that was not accurate to this specific facility and failed to include specific procedures for employees to take during a fire or similar emergency.<br><br>The FSEP did not identify specific fire protection actions for residents evident by not including in writing the procedures required specifically for residents during a fire or similar emergency.<br><br>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 in writing, evacuation status/ unique and unusual needs of | 0 810 | | |

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|---|---|---|---|---|
| 0 810 | Continued From page 11<br><br>each individual resident for evacuation during an emergency.<br><br>During an interview on February 6, 2024, at 11:20 a.m., PPM-E and CNS/O-A, stated employee and resident actions/ procedures required during a fire or similar emergency were not accurate, updated, and specific to this facility. It was also stated by PPM-E, and CNS/O-A, the evacuation status, unique and unusual needs of each individual resident was not included in the FSEP.<br><br>TRAINING<br><br>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 providing documentation of training that was not specific to fire safety and evacuation training for this facility.<br><br>During an interview on February 6, 2024, at 11:35 a.m., PPM-E, and CNS/O-A, stated the training documentation did not state the training provided was specific to the FSEP for this facility.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 0 820 SS=G | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having | 0 820 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| 0 820 | Continued From page 12<br><br>jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff.<br><br>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 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).<br><br>Findings include:<br><br>On a facility tour on February 6, 2024, at 11:15 a.m. with physical plant manager (PPM)-E and clinical nurse supervisor/owner (CNS/O)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room number 6.<br><br>Occupied Resident Rooms<br><br>Resident sleeping room number 6, occupied by R2, emergency escape and rescue clear window opening measurements are 18 inches wide, 35.5 inches in height and 639 square inches in | 0 820 | This immediate correction order identified on February 6, 2024, has had the immediacy lifted as of February 7, 2024, however non-compliance remained a scope and level of G. | |

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|---|---|---|---|
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|---|---|---|---|---|
| 0 820 | Continued From page 13<br><br>openable area. The window was measured with PPM-E and CNS/O-A, and survey staff present. The window did not meet the minimum requirements for clear opening width and minimum clear opening area.<br><br>It was explained to PPM-E and CNS/O-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room.<br><br>Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. And have a windowsill height from the floor to the clear opening of not more than 48 inches.<br><br>These deficient conditions were visually verified by PPM-E and CNS/O-A, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings.<br><br>TIME PERIOD FOR CORRECTION: Immediate. | 0 820 | | |
| 01830 SS=F | 144G.71 Subd. 14 Renewal of prescriptions<br><br>Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure prescriptions | 01830 | | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| 01830 | Continued From page 14<br>were renewed at least every 12 months for two of three residents (R1, R2).<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 began receiving assisted living services on April 1, 2020. R1 received services to include assistance with medication management, mobility, dressing and grooming.<br><br>On February 5, 2023, at 2:15 p.m., unlicensed personnel (ULP)-B was observed to assist R1 with medication administration.<br><br>R1's medication administration record (MAR) for February 2023, indicated R1 was administered the following medications daily:<br>-bacitracin (antibiotic ointment), 500 units (u)/gram (g)<br>-bumetanide (for water retention), 1 milligram (mg)<br>-famotidine (for stomach acid), 20 mg<br>-fluticasone nasal spray (for nasal congestion), 50 micrograms (mcg)<br>-klor-con pak (potassium supplement), 20 milliequivalent (mEq)<br>-losartan potassium (supplement), 50 mg<br>-nystatin powder (for fungal infection), 60 g<br>-sertraline (for depression), 100 mg<br>-vitamin D3 (supplement), 25 mcg | 01830 | | |

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|---|---|---|---|---|
| 01830 | Continued From page 15<br><br>-acetaminophen (for mild pain), 650 mg<br>-atorvastatin (for cholesterol), 40 mg<br>-prazosin (for hypertension), 1 mg<br>-quetiapine (for bipolar disorder), 100 mg<br>-trazadone (for depression), 150 mg<br><br>R2<br>R2 began receiving assisted living services on November 18, 2020. R2 received services to include assistance with medication management, housekeeping and laundry.<br><br>On February 6, 2023, at 8:30 a.m., unlicensed personnel ULP-D was observed to assist R2 with medication administration.<br><br>R2's MAR for February 2023, indicated R2 was administered the following medications daily:<br>-venlafaxin (for depression), 150 mg<br>-vitamin D3 (supplement), 20 mcg<br>-creon capsule (enzyme supplement), 24000 units (u)<br>-fluoxetine (for depression), 10 mg<br>-gabapentin (for nerve pain), 200 mg<br>-insulin lispro (for diabetes), 2 U<br>-sodium bicarbonate (for indigestion), 650 mg<br>-sodium chloride (supplement), 1 gm<br>-ferrous sulfate (iron supplement), 325 mg<br>-xarelto (to prevent blood clot), 20 mg<br>-amlodipine (for hypertension), 5 mg<br>-carvedilol (for hypertension), 6.25 mg<br>-lantus (insulin-for diabetes), 100 u/millileter<br>-lubiprostrone (for constipation), 24 mcg<br>-polyethylene glycol 3350 powder (for constipation), 1 packet<br>-senexon-s (for constipation), 8.6-50 mg<br>-simvastatin (for cholesterol), 5 mg<br><br>R1 and R2's record included prescriber orders signed May 20, 2020, and November 11, 2020, | 01830 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01830 | Continued From page 16<br><br>respectfully. R1 and R2's record lacked updated orders signed within the last 12 months.<br><br>On February 7, 2023, at 1:00 p.m., clinical nurse supervisor/owner (CNS/O)-A stated the orders in R1 and R2's record were the most current orders they had. CNS/O-A acknowledged signed orders needed to be updated every 12 months and stated she would implement this process.<br><br>The licensee's 7.18 Medication and Treatment Orders-Renewal policy, dated August 1, 2021, indicated medication orders would be sent to the provider for signature at least every 12 months, and kept in the resident's record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01830 | | |
| 02310 SS=D | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure that oxygen cylinders were properly stored for one of one resident (R4).<br><br>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 | 02310 | | |

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|---|---|---|---|---|
| 02310 | Continued From page 17<br><br>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).<br><br>The findings include:<br><br>R4 admitted to the facility April 9, 2020, with diagnosis to include stroke.<br><br>On February 6, 2024, at 9:15 a.m., the surveyor observed four oxygen cylinders in R4's bedroom. Each cylinder was observed to be unsecured standing upright to the right of the closet door. Unlicensed personnel (ULP)-D stated she had been trained on oxygen and the cylinders were "kept in the corner."<br><br>On February 7, 2024, at 10:10 a.m., ULP-B stated R4's oxygen tanks were kept "accessible" in the bedroom. ULP-B further stated they did not recall being trained on oxygen storage.<br><br>On February 7, 2024, at 1:00 p.m., clinical nurse supervisor/owner (CNS/O)-A stated oxygen cylinders were kept in R4's bedroom "in case of an emergency", and additional cylinders were kept in "a crate downstairs." CNS/O-A further stated she was unaware the cylinders in the bedroom needed to be secured in a rack.<br><br>The licensee's 7.40 Oxygen policy dated, August 1, 2021, lacked documentation for secured storage of oxygen cylinders in chains or racks.<br><br>The Minnesota Department of Health Oxygen Cylinder Storage Requirements, dated April 16, 2020, noted, "cylinders must be secured (chains | 02310 | | |

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|---|---|---|---|---|
| 02310 | Continued From page 18<br>or racks) to prevent them from falling over."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02310 | | |
| 02430 SS=C | 144G.91 Subd. 15 Confidentiality of records<br><br>(a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party.<br>(b) Residents have the right to access their own records.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private for four of five residents (R1, R2, R4, R5).<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include: | 02430 | | |

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|---|---|---|---|
| | 34811 | A. BUILDING: _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AT HOME WITH US LLC | 2174 STANICH STREET MAPLEWOOD, MN 55109 |

| (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 |
|---|---|---|---|---|
| 02430 | Continued From page 19<br><br>R1 admitted to the facility April 1, 2020, with diagnosis to include respiratory failure.<br><br>R2 admitted to the facility November 18, 2020, with diagnosis to include diabetes.<br><br>R4 admitted to the facility April 9, 2020, with diagnosis to include stroke.<br><br>R5 admitted to the facility January 5, 2021, with diagnosis to include traumatic brain injury.<br><br>On February 5, 2024, at 1:30 p.m., the surveyor observed an iPad visible on an end table next to a couch in the staff room. R2's first name was visible on the iPad along with the number 251 milligrams per deciliter (mg/dL). The surveyor further observed a document titled "medication with special ins" taped to the door exiting the staff room. A smaller pink piece of paper with the word "attention" was taped to the top of the document, and a table holding board games and card games was against the door, below the document. The document contained names of residents (R1, R2, R4, R5), some of the medications they took, possible side effects of the medications, and parameters for giving the medications.<br>-at 1:45 p.m., 1:50 p.m., and 2:05 p.m., the iPad read 245, 238, and 230 mg/dL, respectfully.<br>-at 2:05 p.m., unlicensed personnel (ULP)-B stated the iPad was open to an application that monitored R2's blood sugar, and she thought the application "has to stay open to work." ULP-B further stated some of the residents who are mobile will "sometimes" enter the staff room.<br>-at 3:30 p.m., ULP-C stated R2 and R3 will enter the staff room and "hang out" at times.<br><br>On February 6, 2024, at 8:30 a.m., clinical nurse supervisor/owner (CNS/O)-A stated R2 has a | 02430 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34811 | A. BUILDING: _____ B. WING _____ | 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AT HOME WITH US LLC | 2174 STANICH STREET MAPLEWOOD, MN 55109 |

| (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 |
|---|---|---|---|---|
| 02430 | Continued From page 20<br><br>Dexcom sensor (a glucose sensor connected to a transmitter which sends glucose data to a wireless system receiver or a compatible smart device) and they track R2's blood sugar on an iPad application that is kept in the staff room. CNS/O-A further stated residents are only allowed in the staff room when staff are present because they "have some private information in there." The surveyor noted a "staff only" sign posted on the door to the entry of the staff room.<br>-at 1:57 p.m., the surveyor observed R3 enter the staff room unattended, take a gaming tablet off the table below the document, and exit the room.<br>-at 2:13 p.m., R3 entered the staff room unattended, retrieved a cordless telephone, and exited the room.<br>-at 3:14 p.m., R3 entered the staff room unattended, rummaged through the games and cards on the table below the document, retrieved a deck of cards, and exited the room.<br><br>On February 7, 2024, at 1:00 p.m., CNS/O-A stated she was not aware R3 had been entering the staff room unattended.<br><br>The licensee's 2.36 Resident Record-Confidentiality policy, dated August 1, 2021, indicated resident records would be kept confidential and locked in a secure area where only authorized staff have access.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02430 | | |

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/06/24*
Time: 08:21:58
Report: 1050241015

# Food and Beverage Establishment Inspection Report



**Location:**
At Home With Us Llc
2174 Stanich Street
Maplewood, MN55109
Ramsey County, 62

**Establishment Info:**
ID #: 0038537
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6518886585
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.

**2-200 Employee Health**

***2-201.11C*** ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE DURING WALK-THROUGH INSPECTION. OPERATOR COULD NOT FIND DOCUMENT. EXCLUSION AND LOGGING REQUIREMENTS REVIEWED. MDH LOG FORM SENT WITH REPORT.

*Comply By: 02/07/24*

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

Inspection was completed with Stephen Derosier, Maria Derosier and MDH Andrew Spaulding. Facility had five residents on site at time of inspection. Meals are prepared on site. This establishment has a residential kitchen. The kitchen has wood cabinets with a hollow base and LVP flooring. All found to be in good condition. A two basin sink is located in the kitchen discussed using one basin designated for 3 compartment sink. Dish machine was not tested due to work order. Verified using thermal label and had a utensil surface temperature of at least 160F for previous uses.

Currently using 100% paper products until dishwasher has been serviced and fixed on placed 1/17/24 with Warner Stallion.

Rapid Care Blood Pathogen Kit / Sani-Cloth Wipes

Discussed the following:
-Employee illness policy and logging requirements

# Food and Beverage Establishment Inspection Report



-Hand Washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

**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 1050241015 of 02/06/24.

Certified Food Protection Manager: Stephen J. Derosier

Certification Number: FM105259 Expires: 02/23/24

**Inspection report reviewed with person in charge and emailed.**

Signed: _____

Maria Derosier
Operator

Signed: _____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us