



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 22, 2025

Licensee

Advance Group Homes Inc.
9118 Blaisdell Avenue South
Minneapolis, MN 55420

RE: Project Number(s) SL36624015

Dear Licensee:

On June 2, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 28, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Renee L. Anderson'.

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

December 5, 2024

Licensee

Advance Group Homes Inc
9118 Blaisdell Avenue South
Minneapolis, MN 55420

RE: Project Number(s) SL36624015

Dear Licensee:

Please Note: This notice amends the enforcement letter dated October 7, 2024. Specifically, correction order 0100 was amended to reflect accurate description of dwelling. Also, please note that an additional request for an informal conference has been included in this amended letter. Refer to this notice and revised state form for additional details.

The Minnesota Department of Health (MDH) completed a survey on August 28, 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 . . ."

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>

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule a conference call with Advance Group Homes Inc. Please contact Renee L. Anderson at 651-201-5871 **on or before December 10, 2024**, to schedule the conference call.

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, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER ADVANCE GROUP HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9118 BLAISDELL AVENUE SOUTH MINNEAPOLIS, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36624015-0 On August 26, 2024, through August 28, 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, the licensee had 4 residents; all of whom were receiving services under the provider's Assisted Living Facility license. The content of the 0100 order was edited on November 26, 2024, and the amended enforcement letter provided to the licensee. The scope and severity of the order remained the same (level 2, widespread).	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. 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 pursuant to 144G.31 Subd. 1, 2 and 3.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 100	Continued From page 1 provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by:	0 100			

Minnesota Department of Health

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0 100	Continued From page 2 Based on observation, interview, and record review, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility. Non-assisted living occupants reside on one side of the duplex, and the licensee does not have access to all areas of the facility This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 26, 2024, at 7:00 a.m., during survey preparation, the surveyor noted the facility address listed in the Department record to be 9118 Blaisdell Avenue (Ave) South (S), Minneapolis, Minnesota (MN) 55420. On August 26, 2024, at 10:30 a.m., the surveyor arrived at 9118 Blaisdell Ave S, Minneapolis, MN 55420, and observed the assisted living facility located in a building with two connected dwelling units, sharing the same roof, with separate entrances and separate addresses. The address for the dwelling unit connected to the assisted living facility was 9120 Blaisdell Ave S, Minneapolis MN 55420. The surveyor knocked on the door to 9118 Blaisdell Ave S, and there was no answer. Unlicensed personnel (ULP)-B came out of the front entrance to 9120 Blaisdell Ave S, and stated the assisted living facility was located at the 9120 Blaisdell Ave S address.	0 100			

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0 100	Continued From page 3 On August 26, 2024, at 2:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the owner of the assisted living facility also owned the property and was renting out the dwelling unit located at 9118 Blaisdell Ave to a husband and wife with three teenage children and the connected unit was not a part of the assisted living facility. The licensee's Application for Assisted Living License signed on December 20, 2023, indicated on page 1, the physical address of the facility was 9118 Blaisdell Ave S, Minneapolis, MN 55420. The Application further indicated on page 5 and page 6, with a check mark, the licensee declared was the owner or authorized agent and attested to reading Minn. Stat. chapter 144G and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee was legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480			

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0 480	Continued From page 4 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 26, 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			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650			

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0 650	Continued From page 5 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content, including annual performance reviews for one of two employees (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-C was hired on October 21, 2022. RN-C's employee record lacked documentation of annual performance reviews.	0 650			

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0 650	Continued From page 6 On August 27, 2024, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was responsible for completing the RN's annual performance reviews and he had forgotten to do them. The licensee's Personnel Records policy, dated September 6, 2022, indicated annual performance reviews would be maintained in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 660			

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0 660	Continued From page 7 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 interferon gamma release assay (IGRA) blood test was completed and documented for two of two employees (registered nurse (RN)-C, unlicensed personnel (ULP)-B). 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: RN-C RN-C was hired October 21, 2022, to provide direct cares and services to residents, supervise staff and perform managerial duties. RN-C's employee record contained an IGRA blood test, dated June 21, 2021, greater then 90 days (487 days) prior to hire. ULP-B ULP-B was hired February 24, 2023, to provide direct cares and services to residents. ULP-B's employee record contained a first step TST, dated March 28, 2023, but lacked documentation of a second step TST being completed.	0 660			

Minnesota Department of Health

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0 660	Continued From page 8 On August 27, 2024, at 8:30 a.m., the surveyor observed ULP-B assist R1 with medication administration. On August 27, 2024, at 3:00 p.m., licensed assisted living director (LALD)/RN-A stated he did not realize a blood test could not be more than 90 days before hire. LALD/RN-A further stated he had asked ULP-B to get the second step TST done and was not aware it had not been completed. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening/Prevention policy, dated September 6, 2022, indicated baseline testing would be completed upon hire and would consist of either a two-step TST or single IGRA blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

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0 660	Continued From page 9 (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 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.	0 680			

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0 680	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living EP plan, last reviewed by the licensee July 24, 2024, lacked the following required content: -EP testing requirements including an annual full-scale exercise or individual facility-based functional exercise. On August 28, 2024, at 11:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was not aware of the annual full-scale exercise or individual facility-based functional exercise requirement and thought the plan contained all the required content. The licensee's Emergency Preparedness policy, dated September 6, 2022, indicated the emergency preparedness plan would conduct a disaster drill at least annually and the results would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 780	Continued From page 11	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 the required smoke alarm immediately outside within the vicinity of the lower-level resident sleeping room 3 and failed to provide smoke alarms that are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect all residents, staff, and visitors.	0 780			

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NAME OF PROVIDER OR SUPPLIER ADVANCE GROUP HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9118 BLAISDELL AVENUE SOUTH MINNEAPOLIS, MN 55420		
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0 780	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, survey staff observed the following: -A missing smoke alarm in the lower-level hallway immediately outside of resident sleeping room 3. Survey staff explained to LALD/RN-A there is a door (closed position at time of tour) separating the hallways between sleeping rooms 3 and 4 and the smoke alarm located outside the hallway of room 4 would not properly detect and provide coverage for the hallway of sleeping room 3. LALD/RN-A verified and acknowledged the deficient finding at the time of discovery. LALD/RN-A stated they would install another smoke alarm outside of room 3. -The smoke alarms in the home were not interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout as required. The deficient finding was evident when LALD/RN-A tested the smoke alarms inside resident sleeping rooms 3, and 4, and on the upper-level and lower-level hallways, each smoke alarm sounded locally and did not activate the other smoke alarms in the home to operate and sound.	0 780			

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0 780	Continued From page 13 The above deficient findings were verbally and/or visually verified by LALD/RN-A at the time of discovery accompanying the home tour. Survey staff advised LALD/RN-A that the home had existing hardwired smoke alarm housings throughout without smoke alarm devices installed (except for resident room 3) as there were exposed wires within the alarm housings. When asked about the missing hardwired smoke alarm devices, LALD/RN-A stated he had discarded them. Survey staff explained to LALD/RN-A that the state standard requires that existing hardwired smoke alarms must be maintained, but new smoke alarms could be battery-type to comply with the assisted living statutes. On August 26, 2024, at approximately 2:30 p.m., survey staff explained the above deficient findings to LALD/RN-A during an interview. LALD/RN-A understood and acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

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0 800	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, survey staff observed the following: -The licensee lacked maintenance for proper roof drainage to protect the home. Debris and branches were observed on the perimeter of the roof gutter system. LALD/RN-A verified the finding and stated they would clean out the roof gutter system. - The air duct grille and exhaust fan cover in the main-level bathroom were covered with thick dust. -The egress window hardware in resident sleeping room 4 did not have a handle attached to allow the window to be readily openable for	0 800			

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0 800	Continued From page 15 immediate use. The finding was evident as the handle was sitting on the windowsill. -The egress window opening for the resident sleeping room 3 was obstructed by a window well cover. Survey staff explained to LALD/RN-A that egress sleeping windows must not be obstructed and be operable and openable for immediate use. -Lower-level floor resident room 4 carpet flooring was unmaintained and soiled. The above deficient findings were verbally and/or visually verified by LALD/RN-A at the time of discovery. On August 26, 2024, at approximately 2:30 p.m., survey staff explained the above deficient findings to LALD/RN-A during an interview. LALD/RN-A understood and acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810			

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0 810	Continued From page 16 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all 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	0 810			

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0 810	Continued From page 17 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, survey staff observed the following: -The posted fire evacuation diagram (plan) for the main floor did not include room numbers for each resident bedroom or evacuation routes for resident movements during a fire or similar emergency. Evacuation plans must include the location of resident sleeping room numbers and evacuation routes. -The lower-level floor did not have a posted fire evacuation diagram (plan). In addition, the lower-level evacuation plan was not available or provided for review during an interview. The above deficient findings were visually and/or verbally verified by LALD/RN-A at the time of discovery. On August 26, 2024, at approximately 2:00 p.m., document and record review and interview with LALD/RN-A, on the home's fire safety and evacuation plan, and related training policies, procedures, and records indicated the following: -Document review indicated the licensee's fire safety and evacuation plan failed to include site-specific employee actions in the event of a fire or similar emergency relative to the facility's building layout and conditions, and resident movements during a fire or similar emergency. -Document review indicated the residents'	0 810			

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0 810	Continued From page 18 evacuation and relocation plan, section 1.12, dated September 6, 2022, did not list the correct alternate home address during an emergency relocation. The plan incorrectly listed 9118 Blaisdell as the alternate home which is occupied by a residential rental resided by a private party that was in no way associated with the licensee. In addition, the home's resident emergency evacuation report, printed with date Aug 26, 2024, listed 1523 Girard Avenue North Minneapolis, as the relocation location. -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, LALD/RN-A verified that the fire safety and evacuation plan did not include these provisions. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year. LALD/RN-A confirmed the finding and stated that the licensee only provided training at the time of resident move-in, but no records were available for review. In addition, LALD/RN-A was unable to provide any documentation showing any training offered to residents on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month. Record review indicated that a total of one evacuation drill was conducted to date for the year 2024, a total of two drills were conducted for	0 810			

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0 810	Continued From page 19 calendar 2023, and no records were provided or available for 2022. LALD/RN-A stated that the first- and second-shift employees performed evacuation drills together which survey staff clarified to LALD/RN-A that evacuation drills must be performed on the actual employee work shift rather than combined shifts, and at a minimum of twice per shift per year, and every other month. The above deficient findings were verified by LALD/RN-A during the interview. On August 26, 2024, at approximately 2:30 p.m., survey staff explained the above deficient findings to LALD/RN-A. LALD/RN-A understood and acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under	01290			

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01290	Continued From page 20 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure six of six employees (unlicensed personnel (ULP)-B, ULP-D, ULP-E, ULP-F, ULP-G, ULP-H) were affiliated with the assisted living license as required. This had the potential to affect the licensee's three current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B, ULP-D, ULP-E, ULP-F, ULP-G, and ULP-H were hired February 24, 2023, October 8, 2023, July 20, 2023, July 17, 2024, May 17, 2024, and February 24, 2023, respectively, to provide direct care services to the licensee's residents. On August 27, 2024, at 1:00 p.m., the surveyor observed the licensee's NETStudy 2.0 Roster online which indicated the employees were eligible and had been fingerprinted under the licensee's previous comprehensive home care license. -at 1:10 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated	01290			

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01290	Continued From page 21 owner (O)-I submitted all the background studies for the staff, and he thought O-I used the license associated with the business address. -at 5:31 p.m., via email, LALD/RN-A provided the surveyor with background studies for the licensee's staff. ULP-B, ULP-D, ULP-E, ULP-F, ULP-G, and ULP-H had cleared background studies affiliated with the licensee's comprehensive home care license. The staff lacked a background study affiliated with current license. On August 28, 2024, via email at 7:42 a.m., O-I stated the licensee operated at the location of the survey. O-I further stated the address affiliated with the staff background studies was the licensee's old business address. The licensee's Recruitment and Hiring Policy, dated September 6, 2022, indicated, "The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS". No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:	01500			

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01500	Continued From page 22 (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated	01500			

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01500	Continued From page 23 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual training included all required topics was completed for each 12 months of employment for two of two employees (registered nurse (RN)-C, unlicensed personnel ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-C RN-C was hired October 21, 2022, to provide direct cares and services to residents, supervision of staff and perform managerial duties. RN-C's employee record lacked evidence they had successfully completed at least eight hours for every 12 months of employment as required	01500			

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01500	Continued From page 24 under 144G.63, Subd.5, to include the following: - review of provider's policies and procedures - principles of person-centered planning/service delivery ULP-B ULP-B was hired February 24, 2023, to provide direct cares and services to residents. On August 27, 2024, at 8:30 a.m., the surveyor observed ULP-B assist R1 with medication administration. ULP-B's employee record lacked evidence they had successfully completed at least eight hours for every 12 months of employment as required under 144G.63, Subd.5, to include the following: -infection control techniques -review of provider's policies and procedures On August 28, 2024, at 11:30 p.m., licensed assisted living director (LALD)/RN-A stated the RN was responsible for assigning staff training and it looked like some of the required topics were missed. The licensee's Staff Orientation and Education policy, dated September 6, 2022, indicated staff would complete at least eight hours of education for every 12 months of employment and the education topics would include a review of the organization's policies and procedures, infection control techniques, and the principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER ADVANCE GROUP HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9118 BLAISDELL AVENUE SOUTH MINNEAPOLIS, MN 55420		
(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
01760	Continued From page 25	01760			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medication was administered as prescribed for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted with diagnoses to include depression.	01760			

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01760	Continued From page 26 R1's Service Plan dated March 17, 2024, indicated R1 received services to included medication management. R1's signed provider order, dated December 18, 2023, indicated R1 received one 100 milligram (mg) tablet of clozapine (used to treat schizophrenia and suicidal thoughts) in the morning and three 100 mg tablets of clozapine at bedtime. On August 26, at 10:30 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated the pharmacy set up medications for the licensee's residents. On August 27, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R1 with medication administration. ULP-B retrieved R1's medication tote from a locked cabinet, brought the tote to the living room, and set it on a coffee table. ULP-B removed a bubble pack, prepared by the pharmacy, that contained R1's medications for that morning. ULP-B punched out the medications from the bubble pack and put them into a medication cup. ULP-B then took a medication bottle out of the tote, with a prescription label that read clozapine 100 mg. ULP-B dispensed three tablets from the bottle into the medication cup. LALD/RN-A stopped ULP-B before the medications were administered and removed two of the clozapine tablets. The pharmacy-provided bubble pack indicated the following medications were included: 2-sertraline 100 mg tablets (to treat schizophrenia) 1-esomeprazole magnesium 20 mg tablet (to treat acid reflux)	01760			

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01760	Continued From page 27 1-atrovastatine 40 mg tablet (to treat cholesterol) 1-cert-a-vit tablet (vitamin supplement) 1-bupropion 150 mg tablet (to treat anxiety) 1-brexpiprazol 2 mg tablet (to treat depression) 1-propranolol 20 mg tablet (to treat high blood pressure) 1-metformin 1000 mg tablet (to treat type 2 diabetes) On August 27, 2024, at 8:30 a.m., LALD/RN-A stated if he had not intervened and removed the two clozapine tablets, ULP-B would have made a medication error. R2 R2 was admitted with diagnoses to include diabetes. R2's Service Plan dated June 2, 2024, indicated R2 received services to include assistance with medication management. R2's signed provider order, dated June 14, 2024, indicated R2 received one 100 mg tablet of quetiapine (used to treat depression) three times a day. On August 27, 2024, at 9:30 a.m., the surveyor observed ULP-B assist R2 with medication administration. ULP-B retrieved R1's medication tote from a locked cabinet, brought the tote to the living room, and set it on a coffee table. ULP-B removed a bubble pack, prepared by the pharmacy, that contained R1's medications for that morning. ULP-B punched out the medications from the bubble pack and put them into a medication cup. ULP-B then took a medication bottle from the tote with a prescription label that read, "quetiapine 100 mg take one tablet by mouth three times daily." ULP-B took	01760			

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01760	Continued From page 28 one tablet from the bottle, added it to the medication cup, and took the cup to the stairs leading to R2's room. The surveyor intervened before the medications were delivered. The pharmacy-provided bubble pack indicated the following medications were included: 1-omeprazole 20 mg tablet (to treat acid reflux) 1-levothyroxine 112 micrograms (mcg) (to treat hypothyroid) 2-gabapentin 600 mg tablets (to treat nerve pain) 2-vitamin D3 1000 unit tablet (supplement) 2-sertraline 100 mg tablets (to treat depression) 2-levetiracetam 500 mg tablets (to treat seizures) 1-quetiapine 100 mg tablet (to treat depression) On August 27, 2024, at 9:45 a.m., the surveyor observed R2's medication tote with LALD/RN-A. The tote included four pre-set up morning medication bubble packs that included 1 tablet of quetiapine 100 mg and four pre-set bedtime medication bubble packs that included 1 tablet of quetiapine 100 mg. There were also several pre-setup medication bubble packs labeled for morning and bedtime that did not include the quetiapine tablet. LALD/RN-A stated when the pharmacy sent the new cycle of pre-setup medications the bubble packs did not include quetiapine 100 mg because the provider needed to send a new prescription. LALD/RN-A stated when the pharmacy received the updated order, they sent a bottle of quetiapine 100 mg tablets. LALD/RN-A further stated it looked like there were still some of the older pre-setup bubble packs in R2's tote. LALD/RN-A stated it was the RN's responsibly to monitor for unused medications and he was not sure why the medication packets were not removed from R2's tote. LALD/RN-A stated if the medications had been given, it would have been a medication error.	01760			

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01760	Continued From page 29 On August 27, 2024, at 10:45 a.m., ULP-B stated he usually compared the medications listed on the pre-setup bubble packs with the medication administration record (MAR) to ensure accuracy, but the facility internet was not working, and he was having trouble viewing the MAR on a smaller screen. ULP-B further stated he was nervous being observed by a surveyor. The licensee's Medication Administration policy, dated September 6, 2022, indicated the licensed nurse was responsible for assessing medications to ensure all medications were current and to identify any expired or outdated medications. The licensee's Medication Documentation policy, dated September 6, 2022, indicated each medication administered by staff would be documented to include, the resident's name, medication name, medication dosage, date and time administered, method/route administered and signature and title of staff administering the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced	01880			

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01880	Continued From page 30 by: Based on observation and interview, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 27, 2024, at 8:40 a.m., in the presence of licensed assisted living director/registered nurse (LALD/RN)-A, the surveyor observed the contents of the licensee's medication refrigerator. The refrigerator contained six single-use pens of Victoza (used to lower blood sugar), five injector pens of insulin aspart (fast-acting insulin used to lower blood sugar) and two Lantus insulin injector pens (long-acting insulin used to lower blood sugar). The refrigerator contained a digital thermometer to record temperature, but the display was unreadable. LALD/RN-A stated it appeared the thermometer was not working, and he would get it fixed. LALD/RN-A further stated he had not been aware it was not working. The manufacturer's prescribing information for the use of Victoza, dated July 2023, indicated the medication should be refrigerated between 36-46 degrees. The manufacturer's prescribing information for	01880			

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01880	Continued From page 31 the use of Lantus pens, revised June 2023, indicated unopened medication should be refrigerated at 36-46 degrees. The manufacturer's prescribing information for the use of novolog, insulin aspart injection, dated March 2023, indicated the medication should be refrigerated at 36-46 degrees when not in use. The licensee's Storage/Control of Medications policy, dated September 6, 2022, indicated medications requiring refrigeration would be stored at a temperature maintained between 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to discard expired medication for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01890			

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01890	Continued From page 32 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: On August 26, 2024, at 2:30 p.m., the surveyor observed R2's medication tote with licensed assisted living director/registered nurse (LALD/RN)-A and observed the following expired medication: -allergy relief 25 milligrams with an expiration date of May 2024. During the observation, LALD/RN-A stated it was the registered nurse's responsibility to remove expired medications, and he was not sure why it was missed. The licensee's Storage/Control of Medications policy, dated September 6, 2022, indicated the nurse was responsible for monitoring medications for expiration dates. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 7, 2024

Licensee

Advance Group Homes Inc
9118 Blaisdell Avenue South
Minneapolis, MN 55420

RE: Project Number(s) SL36624015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 28, 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 . . ."

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>

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issue

The Department of Health staff would like to schedule a conference call with Advance Group Homes Inc. Please contact Renee L. Anderson at 651-201-5871 **on or before Thursday, October 10, 2024**, to schedule the conference call.

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, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36624015-0 On August 26, 2024, through August 28, 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, the licensee had 4 residents; all of whom were receiving services under the provider's Assisted Living Facility license.	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. 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 pursuant to 144G.31 Subd. 1, 2 and 3.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 100	Continued From page 1 provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by:	0 100			

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0 100	Continued From page 2 Based on observation, interview, and record review, the licensee failed to obtain accurate licensure with the correct physical address, and when they applied for licensure for a residential dwelling, despite sharing one roof with an adjoining dwelling, without having an approved two-hour fire wall. 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 26, 2024, at 7:00 a.m., during survey preparation, the surveyor noted the facility address listed in the Department record to be 9118 Blaisdell Avenue (Ave) South (S), Minneapolis, Minnesota (MN) 55420. On August 26, 2024, at 10:30 a.m., the surveyor arrived at 9118 Blaisdell Ave S, Minneapolis, MN 55420, and observed the assisted living facility located in a building with two connected dwelling units, sharing the same roof, with separate entrances and separate addresses. The address for the dwelling unit connected to the assisted living facility was 9120 Blaisdell Ave S, Minneapolis MN 55420. The surveyor knocked on the door to 9118 Blaisdell Ave S, and there was no answer. Unlicensed personnel (ULP)-B came out of the front entrance to 9120 Blaisdell Ave S, and stated the assisted living facility was located at the 9120 Blaisdell Ave S address.	0 100			

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0 100	Continued From page 3 The licensee lacked evidence there was a 2-hour fire barrier or separation wall to separate the portion of the building licensed as an assisted living facility from the attached residential dwelling. On August 26, 2024, at 2:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he did not have verification there was a 2-hour fire separation between the assisted living facility (9120 Blaisdell Ave) and the attached dwelling (9118 Blaisdell Ave). LALD/RN-A further stated the owner of the assisted living facility also owned the property and was renting out the dwelling unit located at 9118 Blaisdell Ave to a husband and wife with three teenage children and the connected unit was not a part of the assisted living facility. The licensee's Application for Assisted Living License signed on December 20, 2023, indicated on page 1, the physical address of the facility was 9118 Blaisdell Ave S, Minneapolis Minnesota (MN) 55420. The Application further indicated on page 5 and page 6, with a check mark, the licensee declared was the owner or authorized agent and attested to reading Minn. Stat. chapter 144G and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee was legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			

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0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 26, 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			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650			

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0 650	Continued From page 5 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content, including annual performance reviews for one of two employees (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 650			

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0 650	Continued From page 6 The findings include: RN-C was hired on October 21, 2022. RN-C's employee record lacked documentation of annual performance reviews. On August 27, 2024, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was responsible for completing the RN's annual performance reviews and he had forgotten to do them. The licensee's Personnel Records policy, dated September 6, 2022, indicated annual performance reviews would be maintained in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660			

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0 660	Continued From page 7 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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 interferon gamma release assay (IGRA) blood test was completed and documented for two of two employees (registered nurse (RN)-C, unlicensed personnel (ULP)-B). 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: RN-C RN-C was hired October 21, 2022, to provide direct cares and services to residents, supervise staff and perform managerial duties. RN-C's employee record contained an IGRA blood test, dated June 21, 2021, greater than 90 days (487 days) prior to hire. ULP-B	0 660			

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0 660	Continued From page 8 ULP-B was hired February 24, 2023, to provide direct cares and services to residents. ULP-B's employee record contained a first step TST, dated March 28, 2023, but lacked documentation of a second step TST being completed. On August 27, 2024, at 8:30 a.m., the surveyor observed ULP-B assist R1 with medication administration. On August 27, 2024, at 3:00 p.m., licensed assisted living director (LALD)/RN-A stated he did not realize a blood test could not be more than 90 days before hire. LALD/RN-A further stated he had asked ULP-B to get the second step TST done and was not aware it had not been completed. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis	0 660			

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0 660	Continued From page 9 Screening/Prevention policy, dated September 6, 2022, indicated baseline testing would be completed upon hire and would consist of either a two-step TST or single IGRA blood test. 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 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680			

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0 680	Continued From page 10 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: The licensee's Assisted Living EP plan, last reviewed by the licensee July 24, 2024, lacked the following required content: -EP testing requirements including an annual full-scale exercise or individual facility-based functional exercise. On August 28, 2024, at 11:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was not aware of the annual full-scale exercise or individual facility-based functional exercise requirement and thought the plan contained all the required content. The licensee's Emergency Preparedness policy, dated September 6, 2022, indicated the emergency preparedness plan would conduct a disaster drill at least annually and the results would be documented.	0 680			

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0 680	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required smoke alarm	0 780			

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0 780	Continued From page 12 immediately outside within the vicinity of the lower-level resident sleeping room 3 and failed to provide smoke alarms that are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has 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 the potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, survey staff observed the following: -A missing smoke alarm in the lower-level hallway immediately outside of resident sleeping room 3. Survey staff explained to LALD/RN-A there is a door (closed position at time of tour) separating the hallways between sleeping rooms 3 and 4 and the smoke alarm located outside the hallway of room 4 would not properly detect and provide coverage for the hallway of sleeping room 3. LALD/RN-A verified and acknowledged the deficient finding at the time of discovery. LALD/RN-A stated they would install another smoke alarm outside of room 3. -The smoke alarms in the home were not interconnected so the actuation of one alarm would cause all alarms to operate and sound	0 780			

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0 780	Continued From page 13 throughout as required. The deficient finding was evident when LALD/RN-A tested the smoke alarms inside resident sleeping rooms 3, and 4, and on the upper-level and lower-level hallways, each smoke alarm sounded locally and did not activate the other smoke alarms in the home to operate and sound. The above deficient findings were verbally and/or visually verified by LALD/RN-A at the time of discovery accompanying the home tour. Survey staff advised LALD/RN-A that the home had existing hardwired smoke alarm housings throughout without smoke alarm devices installed (except for resident room 3) as there were exposed wires within the alarm housings. When asked about the missing hardwired smoke alarm devices, LALD/RN-A stated he had discarded them. Survey staff explained to LALD/RN-A that the state standard requires that existing hardwired smoke alarms must be maintained, but new smoke alarms could be battery-type to comply with the assisted living statutes. On August 26, 2024, at approximately 2:30 p.m., survey staff explained the above deficient findings to LALD/RN-A during an interview. LALD/RN-A understood and acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800			

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0 800	Continued From page 14 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, survey staff observed the following: -The licensee lacked maintenance for proper roof drainage to protect the home. Debris and branches were observed on the perimeter of the roof gutter system. LALD/RN-A verified the finding and stated they would clean out the roof	0 800			

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0 800	Continued From page 15 gutter system. - The air duct grille and exhaust fan cover in the main-level bathroom were covered with thick dust. -The egress window hardware in resident sleeping room 4 did not have a handle attached to allow the window to be readily openable for immediate use. The finding was evident as the handle was sitting on the windowsill. -The egress window opening for the resident sleeping room 3 was obstructed by a window well cover. Survey staff explained to LALD/RN-A that egress sleeping windows must not be obstructed and be operable and openable for immediate use. -Lower-level floor resident room 4 carpet flooring was unmaintained and soiled. The above deficient findings were verbally and/or visually verified by LALD/RN-A at the time of discovery. On August 26, 2024, at approximately 2:30 p.m., survey staff explained the above deficient findings to LALD/RN-A during an interview. LALD/RN-A understood and acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810			

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0 810	Continued From page 16 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all	0 810			

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0 810	Continued From page 17 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 the potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, survey staff observed the following: -The posted fire evacuation diagram (plan) for the main floor did not include room numbers for each resident bedroom or evacuation routes for resident movements during a fire or similar emergency. Evacuation plans must include the location of resident sleeping room numbers and evacuation routes. -The lower-level floor did not have a posted fire evacuation diagram (plan). In addition, the lower-level evacuation plan was not available or provided for review during an interview. The above deficient findings were visually and/or verbally verified by LALD/RN-A at the time of discovery. On August 26, 2024, at approximately 2:00 p.m., document and record review and interview with LALD/RN-A, on the home's fire safety and evacuation plan, and related training policies, procedures, and records indicated the following:	0 810			

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0 810	Continued From page 18 -Document review indicated the licensee's fire safety and evacuation plan failed to include site-specific employee actions in the event of a fire or similar emergency relative to the facility's building layout and conditions, and resident movements during a fire or similar emergency. -Document review indicated the residents' evacuation and relocation plan, section 1.12, dated September 6, 2022, did not list the correct alternate home address during an emergency relocation. The plan incorrectly listed 9118 Blaisdell as the alternate home which is occupied by a residential rental resided by a private party that was in no way associated with the licensee. In addition, the home's resident emergency evacuation report, printed with date Aug 26, 2024, listed 1523 Girard Avenue North Minneapolis, as the relocation location. -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, LALD/RN-A verified that the fire safety and evacuation plan did not include these provisions. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year. LALD/RN-A confirmed the finding and stated that the licensee only provided training at the time of resident move-in, but no records were available for review. In addition, LALD/RN-A was unable to provide any documentation showing any training offered to residents on the fire safety and evacuation plan.	0 810			

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0 810	Continued From page 19 -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month. Record review indicated that a total of one evacuation drill was conducted to date for the year 2024, a total of two drills were conducted for calendar 2023, and no records were provided or available for 2022. LALD/RN-A stated that the first- and second-shift employees performed evacuation drills together which survey staff clarified to LALD/RN-A that evacuation drills must be performed on the actual employee work shift rather than combined shifts, and at a minimum of twice per shift per year, and every other month. The above deficient findings were verified by LALD/RN-A during the interview. On August 26, 2024, at approximately 2:30 p.m., survey staff explained the above deficient findings to LALD/RN-A. LALD/RN-A understood and acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be	01290			

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01290	Continued From page 20 construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure six of six employees (unlicensed personnel (ULP)-B, ULP-D, ULP-E, ULP-F, ULP-G, ULP-H) were affiliated with the assisted living license as required. This had the potential to affect the licensee's three current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B, ULP-D, ULP-E, ULP-F, ULP-G, and ULP-H were hired February 24, 2023, October 8, 2023, July 20, 2023, July 17, 2024, May 17, 2024, and February 24, 2023, respectively, to provide direct care services to the licensee's residents. On August 27, 2024, at 1:00 p.m., the surveyor	01290			

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01290	Continued From page 21 observed the licensee's NETStudy 2.0 Roster online which indicated the employees were eligible and had been fingerprinted under the licensee's previous comprehensive home care license. -at 1:10 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated owner (O)-I submitted all the background studies for the staff, and he thought O-I used the license associated with the business address. -at 5:31 p.m., via email, LALD/RN-A provided the surveyor with background studies for the licensee's staff. ULP-B, ULP-D, ULP-E, ULP-F, ULP-G, and ULP-H had cleared background studies affiliated with the licensee's comprehensive home care license. The staff lacked a background study affiliated with current license. On August 28, 2024, via email at 7:42 a.m., O-I stated the licensee operated at the location of the survey. O-I further stated the address affiliated with the staff background studies was the licensee's old business address. The licensee's Recruitment and Hiring Policy, dated September 6, 2022, indicated, "The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS". No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01500 SS=F	144G.63 Subd. 5 Required annual training	01500			

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01500	Continued From page 22 (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	01500			

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01500	Continued From page 23 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual training included all required topics was completed for each 12 months of employment for two of two employees (registered nurse (RN)-C, unlicensed personnel ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-C RN-C was hired October 21, 2022, to provide	01500			

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01500	Continued From page 24 direct cares and services to residents, supervision of staff and perform managerial duties. RN-C's employee record lacked evidence they had successfully completed at least eight hours for every 12 months of employment as required under 144G.63, Subd.5, to include the following: - review of provider's policies and procedures - principles of person-centered planning/service delivery ULP-B ULP-B was hired February 24, 2023, to provide direct cares and services to residents. On August 27, 2024, at 8:30 a.m., the surveyor observed ULP-B assist R1 with medication administration. ULP-B's employee record lacked evidence they had successfully completed at least eight hours for every 12 months of employment as required under 144G.63, Subd.5, to include the following: -infection control techniques -review of provider's policies and procedures On August 28, 2024, at 11:30 p.m., licensed assisted living director (LALD)/RN-A stated the RN was responsible for assigning staff training and it looked like some of the required topics were missed. The licensee's Staff Orientation and Education policy, dated September 6, 2022, indicated staff would complete at least eight hours of education for every 12 months of employment and the education topics would include a review of the organization's policies and procedures, infection control techniques, and the principles of	01500			

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01500	Continued From page 25 person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medication was administered as prescribed for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01760			

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01760	Continued From page 26 of the residents). The findings include: R1 R1 was admitted with diagnoses to include depression. R1's Service Plan dated March 17, 2024, indicated R1 received services to included medication management. R1's signed provider order, dated December 18, 2023, indicated R1 received one 100 milligram (mg) tablet of clozapine (used to treat schizophrenia and suicidal thoughts) in the morning and three 100 mg tablets of clozapine at bedtime. On August 26, at 10:30 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated the pharmacy set up medications for the licensee's residents. On August 27, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R1 with medication administration. ULP-B retrieved R1's medication tote from a locked cabinet, brought the tote to the living room, and set it on a coffee table. ULP-B removed a bubble pack, prepared by the pharmacy, that contained R1's medications for that morning. ULP-B punched out the medications from the bubble pack and put them into a medication cup. ULP-B then took a medication bottle out of the tote, with a prescription label that read clozapine 100 mg. ULP-B dispensed three tablets from the bottle into the medication cup. LALD/RN-A stopped ULP-B before the medications were administered	01760			

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01760	Continued From page 27 and removed two of the clozapine tablets. The pharmacy-provided bubble pack indicated the following medications were included: 2-sertraline 100 mg tablets (to treat schizophrenia) 1-esomeprazole magnesium 20 mg tablet (to treat acid reflux) 1-atrovastatine 40 mg tablet (to treat cholesterol) 1-cert-a-vit tablet (vitamin supplement) 1-bupropion 150 mg tablet (to treat anxiety) 1-brexpiprazol 2 mg tablet (to treat depression) 1-propranolol 20 mg tablet (to treat high blood pressure) 1-metformin 1000 mg tablet (to treat type 2 diabetes) On August 27, 2024, at 8:30 a.m., LALD/RN-A stated if he had not intervened and removed the two clozapine tablets, ULP-B would have made a medication error. R2 R2 was admitted with diagnoses to include diabetes. R2's Service Plan dated June 2, 2024, indicated R2 received services to include assistance with medication management. R2's signed provider order, dated June 14, 2024, indicated R2 received one 100 mg tablet of quetiapine (used to treat depression) three times a day. On August 27, 2024, at 9:30 a.m., the surveyor observed ULP-B assist R2 with medication administration. ULP-B retrieved R1's medication tote from a locked cabinet, brought the tote to the living room, and set it on a coffee table. ULP-B removed a bubble pack, prepared by the	01760			

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01760	Continued From page 28 pharmacy, that contained R1's medications for that morning. ULP-B punched out the medications from the bubble pack and put them into a medication cup. ULP-B then took a medication bottle from the tote with a prescription label that read, "quetiapine 100 mg take one tablet by mouth three times daily." ULP-B took one tablet from the bottle, added it to the medication cup, and took the cup to the stairs leading to R2's room. The surveyor intervened before the medications were delivered. The pharmacy-provided bubble pack indicated the following medications were included: 1-omeprazole 20 mg tablet (to treat acid reflux) 1-levothyroxine 112 micrograms (mcg) (to treat hypothyroid) 2-gabapentin 600 mg tablets (to treat nerve pain) 2-vitamin D3 1000 unit tablet (supplement) 2-sertraline 100 mg tablets (to treat depression) 2-levetiracetam 500 mg tablets (to treat seizures) 1-quetiapine 100 mg tablet (to treat depression) On August 27, 2024, at 9:45 a.m., the surveyor observed R2's medication tote with LALD/RN-A. The tote included four pre-set up morning medication bubble packs that included 1 tablet of quetiapine 100 mg and four pre-set bedtime medication bubble packs that included 1 tablet of quetiapine 100 mg. There were also several pre-setup medication bubble packs labeled for morning and bedtime that did not include the quetiapine tablet. LALD/RN-A stated when the pharmacy sent the new cycle of pre-setup medications the bubble packs did not include quetiapine 100 mg because the provider needed to send a new prescription. LALD/RN-A stated when the pharmacy received the updated order, they sent a bottle of quetiapine 100 mg tablets. LALD/RN-A further stated it looked like there were still some of the older	01760			

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01760	Continued From page 29 pre-setup bubble packs in R2's tote. LALD/RN-A stated it was the RN's responsibly to monitor for unused medications and he was not sure why the medication packets were not removed from R2's tote. LALD/RN-A stated if the medications had been given, it would have been a medication error. On August 27, 2024, at 10:45 a.m., ULP-B stated he usually compared the medications listed on the pre-setup bubble packs with the medication administration record (MAR) to ensure accuracy, but the facility internet was not working, and he was having trouble viewing the MAR on a smaller screen. ULP-B further stated he was nervous being observed by a surveyor. The licensee's Medication Administration policy, dated September 6, 2022, indicated the licensed nurse was responsible for assessing medications to ensure all medications were current and to identify any expired or outdated medications. The licensee's Medication Documentation policy, dated September 6, 2022, indicated each medication administered by staff would be documented to include, the resident's name, medication name, medication dosage, date and time administered, method/route administered and signature and title of staff administering the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications	01880			

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NAME OF PROVIDER OR SUPPLIER ADVANCE GROUP HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9118 BLAISDELL AVENUE SOUTH MINNEAPOLIS, MN 55420		
(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
01880	Continued From page 30 An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 27, 2024, at 8:40 a.m., in the presence of licensed assisted living director/registered nurse (LALD/RN)-A, the surveyor observed the contents of the licensee's medication refrigerator. The refrigerator contained six single-use pens of Victoza (used to lower blood sugar), five injector pens of insulin aspart (fast-acting insulin used to lower blood sugar) and two Lantus insulin injector pens (long-acting insulin used to lower blood sugar). The refrigerator contained a digital thermometer to record temperature, but the display was unreadable. LALD/RN-A stated it appeared the thermometer was not working, and he would get it fixed. LALD/RN-A further stated he had not been aware it was not working.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER ADVANCE GROUP HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9118 BLAISDELL AVENUE SOUTH MINNEAPOLIS, MN 55420			
(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
01880	Continued From page 31 The manufacturer's prescribing information for the use of Victoza, dated July 2023, indicated the medication should be refrigerated between 36-46 degrees. The manufacturer's prescribing information for the use of Lantus pens, revised June 2023, indicated unopened medication should be refrigerated at 36-46 degrees. The manufacturer's prescribing information for the use of novolog, insulin aspart injection, dated March 2023, indicated the medication should be refrigerated at 36-46 degrees when not in use. The licensee's Storage/Control of Medications policy, dated September 6, 2022, indicated medications requiring refrigeration would be stored at a temperature maintained between 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER ADVANCE GROUP HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9118 BLAISDELL AVENUE SOUTH MINNEAPOLIS, MN 55420		
(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
01890	Continued From page 32 Based on observation and interview, the licensee failed to discard expired medication for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 26, 2024, at 2:30 p.m., the surveyor observed R2's medication tote with licensed assisted living director/registered nurse (LALD/RN)-A and observed the following expired medication: -allergy relief 25 milligrams with an expiration date of May 2024. During the observation, LALD/RN-A stated it was the registered nurse's responsibility to remove expired medications, and he was not sure why it was missed. The licensee's Storage/Control of Medications policy, dated September 6, 2022, indicated the nurse was responsible for monitoring medications for expiration dates. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Type: Full
Date: 08/26/24
Time: 14:15:46
Report: 1029241256

Food and Beverage Establishment Inspection Report

Page 1

Location:

Advance Group Homes Inc
9118 Blaisdell Avenue South
Minneapolis, MN55420
Hennepin County, 27

Establishment Info:

ID #: 0037991
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6157103715
ID #:

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

The following orders were issued during this inspection.

3-100 Food Characteristics: unadulterated

3-101.11

**** Priority 1 ****

MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.

MOLD ON SLICED CHEESE. DISCARDED BY OPERATOR. OPERATOR INSTRUCTED TO PROVIDE TEMPERATURE CONTROL, DATE MARK, AND BE WATCHFUL FOR SIGNS OF SPOILAGE.

Comply By: 08/26/24

3-500B Microbial Control: hot and cold holding

3-501.16A2

**** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TEMP ABUSED ITEMS IN REFRIGERATOR. ITEMS DISCARDED BY OPERATOR. REFRIGERATOR ADJUSTED FROM 2/3 TO 5, THE COLDEST SETTING. OPERATOR INSTRUCTED TO VERIFY TEMPS OF 41°F OR LESS THROUGHOUT COOLER PRIOR TO PLACING ADDITIONAL TCS ITEMS INTO COOLER.

Comply By: 08/26/24

4-700 Sanitizing Equipment and Utensils

4-703.11C

**** Priority 1 ****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

FOOD CONTACT SURFACE SANITIZER NOT AT ESTABLISHMENT. REP INDICATED THEY WOULD OBTAIN SODIUM HYPOCHLORITE FOOD CONTACT SURFACE SANITIZER AND HAND MIX SOLUTION TO SANITIZE UNTIL SANITIZING DISHWASHER IS INSTALLED. CL

Type: Full
Date: 08/26/24
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Advance Group Homes Inc

Food and Beverage Establishment Inspection Report

OBTAINED AND SOLUTION MADE.

Comply By: 08/26/24

3-500C Microbial Control: date marking

3-501.17B **** Priority 2 ****

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

OPENED HOT DOG, KIELBASA, AND SHREDDED CHEESE PACKAGES W/OUT DATE MARKINGS. OPERATOR INSTRUCTED TO DATE MARK REQUIRED ITEMS AFTER OPENING.

Comply By: 08/26/24

4-300 Equipment Numbers and Capacities

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

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO CL TEST STRIPS. SMALL AMOUNT OF TEST STRIPS PROVIDED AND PICTURE TAKEN OF COLOR CHART FOR CONCENTRATIONS. REP INSTRUCTED TO OBTAIN TEST STRIP SUPPLY TO TEST SOLUTION UNTIL DISHWASHER IS INSTALLED.

Comply By: 08/26/24

4-300 Equipment Numbers and Capacities

4-301.12D

MN Rule 4626.0680D Mechanical warewashing equipment in lieu of a 3-compartment sink may be allowed as long as the warewashing equipment is large enough to accommodate the largest piece of equipment to be washed, rinsed and sanitized.

ESTABLISHMENT W/OUT WORKING SANITIZING DISHWASHER OR 3-COMP SINK. REPRESENTATIVE INDICATED THEY WILL INSTALL A DISHWASHER TO SANITIZE EQUIPMENT AND UTENSILS.

Comply By: 09/27/24

Food and Equipment Temperatures

Process/Item: SOUR CREAM
Temperature: 53 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: Yes

Process/Item: INTERNAL THERMOMETER
Temperature: 52 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: No

Process/Item: SHREDDED CHEESE
Temperature: 55 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: HOT DOGS
Temperature: 50 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Type: Full
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Advance Group Homes Inc

Food and Beverage Establishment
Inspection Report

Process/Item: KIELBASA
Temperature: 51 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: SLICED CHEESE
Temperature: 52 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: SHREDDED CHEESE
Temperature: 54 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: CREAM CHEESE
Temperature: 55 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: YOGURT
Temperature: 54 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: GROUND TURKEY
Temperature: 53 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: SLICED CHEESE
Temperature: 52 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: BACON
Temperature: 53 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: HOT DOG
Temperature: 52 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: MASHED POTATOES
Temperature: 55 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: MAC & CHEESE
Temperature: 60 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: MASHED POTATOES
Temperature: 59 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: MILK
Temperature: 53 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Process/Item: SPINACH SALAD MIX
Temperature: 62 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: Yes

Type: Full
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Advance Group Homes Inc

Food and Beverage Establishment
Inspection Report

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

ESTABLISHMENT W/OUT WORKING DISHWASHER OR 3-COMP SINK. REPRESENTATIVE INDICATED THEY WILL INSTALL A DISHWASHER TO SANITIZE EQUIPMENT AND UTENSILS.

KITCHEN RESIDENTIAL IN NATURE WITH PERGO-ESQUE FLOOR, LAMINATE COUNTERS, TILE BACKSPLASH, SMOOTH PAINTED WALLS, TEXTURED CEILING, AND WOOD/COMPOSITE WOOD DRAWERS AND CABINETS. FOOD SAFETY AND FOODBORNE ILLNESS RISK FACTORS DISCUSSED WITH OPERATOR.

ALL IDENTIFIED ISSUES ADDRESSED WITH OPERATOR DURING INSPECTION. NO SANITIZING DISHWASHER OR 3-COMP SINK. 2-COMP SINK AVAILABLE. NO FOOD CONTACT SURFACE SANITIZER AT ESTABLISHMENT. OPERATOR LEFT TO OBTAIN SODIUM HYPOCHLORITE FOOD CONTACT SURFACE SANITIZER AND SANITIZING BASIN CONTAINER DURING INSPECTION. INSTRUCTIONS PROVIDED TO WASH, RINSE, SANITIZE, AND AIR-DRY USING THE 2-COMP SINK, SANITIZER BASIN, AND DRYING RACK AS A TEMPORARY SANITIZING SOLUTION UNTIL THE DISHWASHER MEETING THE ANSI/NSF 184 STANDARD IS INSTALLED.

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 1029241256 of 08/26/24.

Certified Food Protection Manager: ABIGAEL G. ONSERIO

Certification Number: FM117084 Expires: 05/10/26

Inspection report reviewed with person in charge and emailed.

Signed: 
NASTESHO MAHAMED
STAFF

Signed: 
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241256

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, and Lodging Services

625 Robert Street North

St. Paul

No. of RF/PHI Categories Out

4

Date

08/26/24

No. of Repeat RF/PHI Categories Out

0

Time In

14:15:46

Legal Authority MN Rules Chapter 4626

Time Out

Advance Group Homes Inc

Address

9118 Blaisdell Avenue South

City/State

Minneapolis, MN

Zip Code

55420

Telephone

6157103715

License/Permit #

0037991

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

OUTPIC knowledgeable; duties & oversight

2

IN

OUT N/ACertified food protection manager, duties

Employee Health

3

IN

OUTMgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUTProper use of reporting, restriction & exclusion

5

IN

OUTProcedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT N/ONo 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

OUTAdequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUTFood 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/ONequired records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT N/A N/OFood separated and protected

16

IN

OUT

 N/AFood contact surfaces: cleaned & sanitized

17

IN

OUTProper 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/OProper hot holding temperatures

22

IN

OUT

 N/AFood in good condition, safe, & unadulterated

23

IN

OUT

 N/A N/OProper date marking & disposition

24

IN

OUT

N/A

 N/OTime 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/AFood in good condition, safe, & unadulterated

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 pproceedures 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

IN

OUT

N/A

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

IN

OUT

N/A

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

IN

OUT

N/A

Thermometers provided & accurate

Food Identification

37

IN

OUT

N/A

Food properly labled; original container

Prevention of Food Contamination

38

IN

OUT

N/A

Insects, rodents, & animals not present

39

IN

OUT

N/A

Contamination prevented during food prep, storage & display

40

IN

OUT

N/A

Personal cleanliness

41

IN

OUT

N/A

Wiping cloths: properly used & stored

42

IN

OUT

N/A

Washing fruits & vegetables

Compliance Status

COS

R

Proper Use of Utensils

43

IN

OUT

N/A

In-use utensils: properly stored

44

IN

OUT

N/A

Utensils, equipment & linens: properly stored, dried, & handled

45

IN

OUT

N/A

Single-use/single service articles: properly stored & used

46

IN

OUT

N/A

Gloves used properly

Utensil Equipment and Vending

47

IN

OUT

N/A

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

IN

OUT

N/A

XWarewashing facilities: installed, maintained, & used; test strips

49

IN

OUT

N/A

Non-food contact surfaces clean

Physical Facilities

50

IN

OUT

N/A

Hot & cold water available; adequate pressure

51

IN

OUT

N/A

Plumbing installed; proper backflow devices

52

IN

OUT

N/A

Sewage & waste water properly disposed

53

IN

OUT

N/A

Toilet facilities: properly constructed, supplied, & cleaned

54

IN

OUT

N/A

Garbage & refuse properly disposed; facilities maintained

55

IN

OUT

N/A

Physical facilities installed, maintained, & clean

56

IN

OUT

N/A

Adequate ventilation & lighting; designated areas used

57

IN

OUT

N/A

Compliance with MCIAA

58

IN

OUT

N/A

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date:

08/26/24

Inspector (Signature)

Trevor McCliment